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LOYOLA UNIVERSITY CHICAGO

PRACTITIONERS' EVALUATIONS OF THERAPLAY AS
AN EFFECTIVE TOOL IN SERVING FOSTER AND
ADOPTED CHILDREN AND THEIR FAMILIES

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN SOCIAL WORK

BY

RANA HONG

CHICAGO, IL

AUGUST 2014

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ABSTRACT

Several studies have shown that foster and adopted children have high risk of developing severe mental health problems (Blome & Steib, 2004; Golden, 2009; Leslie, Hurlburt, Landsverk, Barth, & Slyman, 2004; McMillen, Scott, Zima, Ollie, Munson, & Spitznagel, 2004). On the other hand, evidence-based models are limited and less accessible for practitioners working with foster and adopted children (Dorsey, Kerns, Trupin, Conover, & Berliner, 2012). The goal for this study is to explore the practitioners' evaluations of Theraplay®, which is a relationship based model for meeting the pervasive clinical needs of foster and adopted children and their families. Exploring Theraplay in the social work field is meaningful because of its popularity among social workers and the substantial number of clients successfully treated with Theraplay. With Theraplay, attachment theory and neuroscience are applied to understand the necessity of attachment-based models in meeting the needs of foster and adopted children.

A mixed-method research design was selected for this study. It best answered the study's research questions with higher response rates and provided an in-depth exploration in this study (Groves, Fowler, Couper, Lepkowski, Singer, & Tourangeau, 2004). The survey data (N=87) were collected at the 6th International Theraplay Conference on July 11-July 12, 2013 in Evanston, IL. The survey included a demographic questionnaire, which presented questions about the extent of their evaluations of Theraplay, the use of Theraplay in practice, and the Theraplay competency assessment

with a case vignette. One case study was also analyzed for in-depth information. Two focus groups (N=10, 9 respectively) were conducted and the participants were asked to address Theraplay practice and their experiences in the treatment of this population.

The results of the statistical methods (descriptive statistics, correlations test, and one-way ANOVA) found that there is positive association between the levels of practitioners' Theraplay training and the effectiveness of the use of Theraplay for helping foster and adopted children and their families. There is also positive association between the practitioners' levels of competency and the effectiveness of the use of Theraplay for helping foster and adopted children and their families. The case study is an overarching picture of Theraplay practice and highlights the factors in Theraplay that leads to positive therapeutic outcomes. The study found that the therapeutic factors increased parent-child healthy connections, increased self-regulation of the child, parents' increased understanding of their child, and gained skills in parenting. Finally, the findings from the focus groups illustrated that Theraplay helps children build a positive internal working model. It helps parents gain insights and skills for helping their children's emotional and behavioral issues and it is an effective tool for practitioners to help foster and adopted children and families. This research has practical, theoretical, and research implications for social work practice, education, research, and training. These findings have potential to aid many stakeholders: foster and adopted children and their families, clinical social workers, foster and adoption workers, policymakers, and researchers. Informed by the researcher's own clinical experience and expertise through substantive training in the field of Theraplay, this research can be a prototype of the meeting points for clinical, theoretical, and research work in the field of social work.

CHAPTER ONE

INTRODUCTION TO THE STUDY

Overview of the Problem

This study is intended to explore the practice of Theraplay®¹ as an effective tool in serving foster and adopted children and their families. Theraplay is a clinically well established and recognized intervention utilized in helping foster and adopted children and their families with its strength in promoting healthy relationships and attachment (Booth & Jernberg, 2010, 1999; Jernberg, 1979). However, Theraplay research is still in its infancy. With its principals based on attachment theory, the model of Theraplay is the healthy, attuned interactions between parents and their children for enhancing secure attachment and lifelong mental health (Booth & Jernberg, 2010, p. 3). It is even named as “Love Medicine” in Good Housekeeping magazine (2011), in an article depicting testimonial stories about two adoptive families who get tremendous help from Theraplay. The article emphasizes the effects of Theraplay on building powerful bonds between parent and child.

Significance of the relationship between attachment theory and neuroscience is constantly stressed (Perry, 2001; Schore, 2003; Siegel & Hartzell, 2003; Hugh, 2011; Siegel & Bryson, 2011). It is widely accepted that the earliest emotional relationships substantially influence brain development (Davies, 2002; Green, 2003; Siegel & Hartzell,

¹ Theraplay® is registered service mark of The Theraplay® Institute.

2003; Siegel & Bryson, 2011) and that early trauma due to abuse and maltreatment causes harm to the neurological function of affect regulation and autobiographical narrative incoherence (Perry, 2009; Siegel, 2001; Siegel and Bryson, 2011). Currently, research emphasizes the importance of calming and sensitive responses from caregivers to foster optimal brain development when infants and children are distressed (Cicchetti, Rogosch, Toth, 2006; Fosha, 2003; Haltigan, Lambert, Seifer, Ekas, Bauer, Messinger, 2012; Hughes, 2004; Siegel, 2001). Research even suggests that an intervention theoretically rooted in attachment theory (emphasizes affective attuned relationship) is an effective treatment modality for foster and adoptive children (Becker-Weidman, 2006; Bernard, Dozier, Bick, Lewis-Morrarty, Lindhiem, & Carlson, 2012; Hughes, 2004).

Therefore, Theraplay which is theoretically rooted in attachment theory and emphasizes the brain-based function of ‘attunement, empathy, and reflective function’ in its practice (Booth & Jernberg, 2010, p. 58) is the best fit for intervening in the issues of foster and adopted children. Furthermore, exploring Theraplay in the social work field is meaningful because of its popularity among social work practitioners and a substantial number of clients treated in Theraplay. Since its 1969 founding, The Theraplay Institute (TTI) has provided Theraplay training in over 29 countries (Booth & Jernberg, 2010).

In the United States, there are more than 10 Theraplay training workshops every year and each workshop includes up to 30 practitioners from different mental health disciplines. With training leadership under the direction of the social workers (Training Advisor, Sandra Lindaman, L.C.S.W, and Training Director, Dafna Lender, L.C.S.W), TTI trains many social workers in Theraplay each year. Since 1998, there have been

6,245 Theraplay-trained practitioners added in the United States (reports from TTI training Database on April 2013). About 60 % of the new trainees (N=3,747) are social work practitioners (personal communication with Dafna Lender, LCSW, Training director at TTI). If I assume that the average caseload of each social work practitioner is 10 clients per week (though it is usually higher), there may be approximately 36,470 children treated in Theraplay by social worker practitioners each week.

Research Gap

To date, there are only three identified evidence-based practice models, specifically for foster children who are physically and sexually abused: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Abused-Focused Cognitive Behavioral Therapy (AF-CBT) and Parent-Child Interaction Therapy (PCIT) (Koffman Best Practice Projects, 2004). However, standard CBT protocols may be insufficient to deal with multifaceted symptoms manifested by these children (Cloitre, Koenen, Cohen, & Han, 2002; Hugh 2004; Saywitz, Mannarino, Berliner, & Cohen, 2000). Parent-Child Interaction Therapy (PCIT) which is empirically supportive parent training therapy for children with mental health problems (Eyberg, Nelson, & Boggs, 2008; Herschell & McNeil, 2005; Herschell, Calzada, Eyberg, & McNeil, 2002, etc.) is effective and optimally used only with young children (usually aged 3.5 to 7 years). Although the importance of identifying and disseminating more evidence-based interventions for the treatment of children and adolescents is constantly stressed (Glieb & Cuellar, 2003), some are concerned that evidence-based practice is limited and less accessible to foster and adopted children (Dorsey, Kerns, Trupin, Conover, & Berliner, 2012).

To fill in the gaps in the scope of current evidence-based practice models in meeting the pervasive clinical implications with foster and adopted children, exploration of more evidence-based interventions are urgently needed. Considering elements of Theraplay which not only meet the requirements of attachment theory but also contain core concepts emphasized by neuroscience which is essential in dealing with complex symptoms of children, it is valuable to learn practitioners' evaluation of the utilization of Theraplay for this population. Additionally, exploring practitioners' evaluations of Theraplay is appropriate in the context of research. By studying practitioners' perceptions, skills, and knowledge pertaining to the use of Theraplay as an intervention, we can expand the scope of its applicability (Fitzgerald, K., Henriksen, R., & Garza, Y, 2012).

Research Questions and Hypotheses

This is a mixed-methods study with qualitative components and a survey design to answer the following five research questions.

1. How do practitioners evaluate the use of Theraplay in treating the needs of foster and adopted children and their families?
2. How do practitioners describe that use of Theraplay in treating the needs of foster and adopted children and their families?
3. How do practitioners view the effectiveness of the use of Theraplay to help foster and adopted children and their families?
4. What is the relationship between practitioners' Theraplay practice and their evaluations of Theraplay?

5. What is the relationship between practitioners' competency and their evaluations of Theraplay?

The figure 1 illustrates the conceptual diagram depicting the relationships between the variables for this study. As it is shown in Figure 1, both professional experience and practitioners' competency are hypothesized to influence Theraplay practice with foster and adoptive children. Theraplay practice is considered as a determinant of practitioners' evaluation of Theraplay practice and process. Thus, the independent variables, namely professional experience, practitioner's competency, and personal characteristics, are hypothesized to be correlated with dependent variable, namely practitioner's evaluations of the effectiveness of Theraplay in this study.

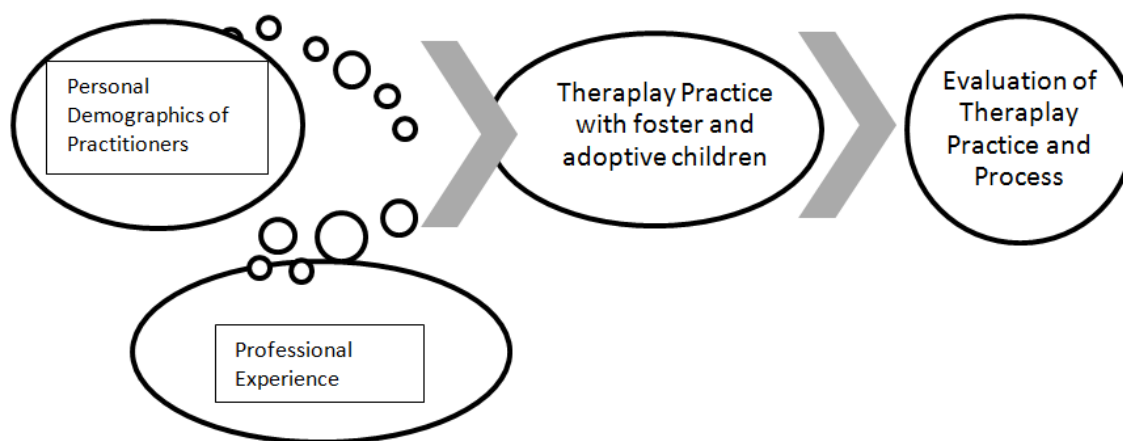


Figure 1. Conceptual Diagram for the Study

Organization of the Study

The purpose of this study is to explore the practitioners' evaluations of Theraplay as an effective tool in serving foster and adoptive children and their families. This dissertation is divided into seven chapters. Chapter I presents an introduction to the research problem, background information, research gap, and addresses the significance

of the study. Chapter II presents the theoretical underpinnings of attachment theory and neuroscience for understanding Theraplay applications to foster and adopted children and their families. The theories introduced demonstrate the value of Theraplay in providing appropriate interventions when dealing with multifaceted symptoms manifested by foster and adopted children and their families. Chapter III presents a review of relevant literature on mental health issues in foster and adopted children, practitioner's competency as well as attachment based interventions including Theraplay. Chapter IV highlights methodology used in this study including the research design, sampling, data collection, instruments, data analysis, and ethical considerations. Chapter V presents the findings and results of this study. Chapter VI presents the discussion of the findings. Chapter VII presents the implications of this study. Finally, Chapter VIII concludes the study.

CHAPTER TWO

THEORETICAL FRAMEWORK

The purpose of this chapter is to outline theoretical underpinnings of attachment theory and neuroscience which are the fundamental basis for identifying treatment practices for foster and adopted children and their families. The reflected theories posit the needs of Theraplay application to foster and adopted children and their families who face multifaceted mental health issues.

Attachment Theory

Attachment theory was first presented by John Bowlby to the British Psychoanalytic Society in London in-“The Nature of Child’s Tie to His Mother” (Bowlby, 1958). With his books of *Attachment and loss: Separation anxiety and anger* (1973) and *A Secure base* (1988), Bowlby developed and conceptualized attachment from biology, ethology, and cognitive psychology. He viewed the infant’s need for a caregiver as a primary social need and attachment behavior as “environmentally stable” in an overall context of evolutionary adaptation. He defined attachment behavior as “any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world” (Bowlby, 1988).

Bowlby (1958, 1988) hypothesized that all human infants are predisposed to become attached to their caregivers because caregivers provide sources of emotional

security, comfort, and protection. He emphasized an infant's biological inclination to initiate, maintain, and terminate interaction with its caregiver, and to use this person as a "secure base" for exploration and self-enhancement (Fonagy & Target, 2003). As an offspring of both object relations theory and developmental theory, attachment theory is considered to bridge the gap between general psychology and clinical psychodynamic theory (Fonagy & Target, 2003). It is the theory that most closely informed understanding of multifaceted clinical issues associated with foster and adopted children because it emphasizes the infant-caregiver relationship at the core of the developmental process. Indeed, infant-parent research has constantly supported Bowlby's concept of secure attachment (Fouts, Roopnarone, Lamb, & Evans, 2012; Haltigan, Lambert, Seifer, Ekas, Bauer, & Messinger, 2012; Bernard, Dozier, Bick, Lewis-Morrarty, Lindhiem, & Carlson, 2012). Research emphasizes the critical parental roles of warmth, mutuality, support and security in parent-child relationships in order to form coherent, secure selves in later life. Research further evidences that the ways in which early experiences of attachment to secure and responsive caregivers are an important foundation for later social competence (Haltigan, Lambert, Seifer, Ekas, Bauer, & Messinger, 2012; Kenny & Gallagher, 2002; Marcus & Kramer, 2001).

Attachment: The Internal Working Model (A Representational System)

It is believed in attachment theory that with an emotionally sensitive, positive, and responsive nurturing relationship with their caregivers, infants establish a secure base from which they can explore both their material and interpersonal worlds, and from which they can expand their mastery of the environment and freely apply their abilities

(Bowlby, 1988, p.3). When a child is no longer dependent on the physical presence of his or her mother, his or her thoughts and memories of mother can reassure and comfort him or her, which Bowlby referred to as an internal working model. In other words, the internal working model is a child's internal representation system of himself or herself in relation to a caregiver (p. 20).

There are three fundamental elements in this representation system: the self, other people, and the relationships between them (p. 99). Based on their subjective interactive experiences with parents or caregivers, children develop inner representational models of themselves and others that include both cognitive and affective aspects (p.101). These inner models guide feelings about self and others, expectations of self and others, and behavior in relationships with others (Bowlby, 1988; Bretherton & Munholland, 1999). These inner models reflecting the quality of early attachment experiences, are largely unconscious and consequently do not change easily, but can be revisited and repaired in response to experiences that do not support a current working model (Bretherton & Munholland, 1999; Hugh, 2004; Schore & Schore, 2008; Siegel, 2001).

Through coherent and consistent relationships, children learn the skills of relating to others and feel that they are able to have an impact on the situations they are in. It recognizes that the concepts of dependence and independence are complementary, and that relative independence or interdependence develops from positive relationship experiences early in life when caregivers are consistently reliable and responsive to emotional needs (p.137)

Neuroscience

Recent advances in neuroscience have helped researchers to demonstrate that psychotherapy affects the structure and function of many regions of the brain such as the cortex, limbic system (e.g., amygdala, hippocampus), and basal ganglia (Cozolino, 2006, 2002; Kay, 2009; Siegel, 2001; Siegel & Bryson, 2011). Excitingly, one of core mediums which alters the brain structure is found to be the therapeutic experience or relationship (Kay, 2009; Siegel & Bryson, 2011). Just as attachment researchers suggest that early attachment relationships influence brain development (Davies, 2002; Green, 2003; LeDoux, 200; Perry 2001; Schore, 2003), experience in general sculpts neuronal function and brain structure (Kay, 2009; Siegel, 2001).

Psychotherapy has been relevant to neuroscience since Freud. Freud, a neurologist, was the first to theorize about the construction of the brain and the development of the mind in the late 1800s (Freud, 1990). In *The Project for a Scientific Psychology*, Freud (1990) postulated that interconnecting neurons are related to our conscious and unconscious experience and represent human emotions, behaviors, and psychological defenses. His idea for psychology based on an understanding of the nervous system was obviously far too advanced to gain enough support or attention during that era (Cozolino, 2002). Although the relevance between neuroscience and psychology was primitive, the steady and continued efforts of understanding the human brain have existed since Freud's time.

There has been even greater progress within the last decade toward understanding the neuroscience and psychotherapy. Brain imaging studies have shown evidence that

positive or negative experience can alter brain function and structure (Kay, 2009). The brain is now understood as creating a “neural map” – specific patterns of neural firing or rewiring in particular regions – which serves to create a mental image or representation of an object (Siegel, 2001). By employing ionizing radiation such as neuroimaging, the substantial contribution of neuroscience to explain the relevance of psychotherapy and attachment theory has obviously been much greater in the present era (Kay, 2009).

Understanding the Internal Working Model in the Lens of Neuroscience

The human brain is described as an “organ of adaptation” to the outer worlds; that is, it continues to change, grow, and learn through positive and negative interactions within the environments (Cozoline, 2002). The way the brain changes is very similar to the development of internal working models. Just as enriched environments promote positive function and structure of the brain, children create inner representations of themselves and others that include both cognitive and affective aspects through significant and subjective interactions with parents or caregivers.

Bowlby’s concept of an internal working model is also well supported by the process of memory in the brain. Early attachment experiences with our caregivers become implicit memories that organize the central nervous system into working models of self and others (Kay, 2009; Siegel, 2001; Siegel & Bryson, 2011). Encoded attachment experiences directly influence our here-and-now experiences without clues to their origins from the past events (Siegel, 2001; Siegel & Bryson, 2011). Research has demonstrated that psychotherapy is a means of creating or restoring neural network integration and coordination among various neural networks (Kay, 2009). With the

increasing knowledge of the brain's structure and function, the issue of attachment is again stressed in child psychotherapy (Green, 2003; Perry, 2001; Porges, 2011; Schore, 2003). There is now widespread acceptance that the early attachment relationship with a primary caregiver is crucial to promoting healthy development. The power of brain plasticity also supports that detrimental early influences can be altered by proper interventions (Green, 2003; Perry, 2001; Porges, 2011; Schore, 2003; Siegel, 2001).

Therefore, attachment theory supported by neuroscience is an important theoretical guide in intervening in a myriad of mental health issues in foster and adoptive children. Multifaceted symptoms manifested by foster and adopted children cannot be effectively treated without understanding their brain functions.

CHAPTER THREE

LITERATURE REVIEW

The central purpose of this chapter is four-fold: first, to explore researched evidence in the mental health needs of foster and adopted children; second, to investigate research pertinent to practitioners' competency on current evidence-based models; third, to outline the conceptual and practical understanding of Theraplay; and fourth, to explore researched evidence in attachment-based interventions including Theraplay

Mental Health in Foster and Adopted Children

It was estimated that one in five children and adolescents suffer from mental health problems, and the number is constantly growing (DeAngelis, 2004). Considering trauma issues among foster children, it is not surprising that mental health problems among foster and adopted children are even greater than the general population (Leslie, Hurlburt, Landsverk, Barth, & Slyman, 2004; McMillen, et al., 2004). Leslie et al. (2004) reported that children and adolescents in foster care have considerably high rates of mental health problems, with between 50% and 80% presenting needs requiring clinically significant treatment. Children in foster care are sixteen times more likely to have psychiatric diagnoses and eight times more likely to be taking psychotropic medication than general population (Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005).

One of the primary factors for foster and adoptive children to develop severe mental health issues is a traumatic experience such as child neglect and abuse, exposure

to domestic violence, or separation from their parents (Blome & Steib, 2004; Golden, 2009; Leslie, Hurlburt, Landsverk, Barth, & Slyman, 2004; McMillen et al., 2004). A national study of the mental health needs of children and adolescents involved with child welfare (Burns, et al. 2004) showed that nearly half (47.9%) of the children and adolescents aged two to fourteen (N=3,803) who completed child welfare investigations had clinically significant emotional or behavioral problems. The study also explored their access to mental health services.

A substantial body of evidence has suggested an increase of mental health issues among adopted children (Baden, 2007; Bimmel, Juffer, van IJzendoorn, & Bakermans-Kranenburg, 2003; Hoshmand, Gere, & Wong, 2006; Hoksbergen & Laak, 2007; Juffer and van IJzendoorn, 2005; McGinn, 2007; Mohanty & Newhill, 2005; Verhulst, 2008; Merz & McCall, 2010). Bimmel, et al. (2003) reported that adoptive children have behavioral issues due to poor attachment, lack of biological connections and difficulty with identity formation. It was suggested that not having a biological connection between the parent and the child in adoption threatens the attachment bond of parents and children, potentially negatively impacting the child's behavior (Bimmel, et al., 2003; Hoksbergen & Laak, 2007).

Juffer and van IJzendoorn (2005) conducted a meta-analysis to investigate behavioral issues related to children adopted both domestically and internationally. They used 101 studies (25,281 cases; 80,260 controls) on behavior problems from 12 countries around the world (1961-2004). Fifty-four percent of the studies were conducted in North America. Their four primary results concluded that: 1) both internationally and

domestically adopted children showed more behavioral problems than non-adopted controls ($d=0.18$); 2) domestically adopted children showed more behavioral problems than internationally adopted children ($d=0.02$ vs. $d=0.11$); 3) internationally adopted children with pre-adoption adversity showed more behavioral problems than those without pre-adoption adversity ($d=0.18$ vs $d=0.09$ respectively; contrast: $Q=6.46$; $p<.01$); and 4) internationally adopted children who were adopted from ages 0-12 months did not show significantly different behavior problems than those adopted after 12 months ($Q=2.27$; $p=.13$). Thus, their results supported the notion that higher risk behavioral problems are more prevalent in adoptive children. It also suggested that adoptive children with histories of extreme deprivation, neglect, malnutrition, or abuse have greater risks of mental health issues.

Merz and McCall (2010) investigated six to eighteen-year-old children adopted ($N=342$) from psychosocially depriving Russian institutions that have acceptable physical resources but inconsistent, insensitive, and unresponsive caregiving. Survey research using the parent-reported “Child Behavior Checklist” (CBCL) was conducted with three rounds of data collection (2001, 2003, 2008) with response rates of 40% (2001), 37% (2003), and 51% (2008). It found that these adoptive children had higher rates of clinical/borderline scores on the CBCL attention [$\chi^2 (1, N=780)=6.89$, $p<0.01$], and externalizing problems [$\chi^2 (1, N=780)=4.94$, $p<0.05$]. It also found that there was a strong association between adoptive age and behavioral problems during adolescence.

Overall, prior research investigations have indicated consistent results on prevailing mental health issues in foster and adoptive children.

Practitioners' Competency

With an increased emphasis on evidence-based models in clinical practice in recent years, today more than ever before, practitioners' competence has been stressed in most professions. In order to accurately evaluate Theraplay from the perspectives of practitioners, defining practitioners' competence is very important. The results of practitioners' evaluations on particular models can-not be accurate if their competence is not proven.

The Educational Policy and Accreditation Standards (EPAS), the standards for accreditation by Council of Social Work Education, address its correlation by stating that "program evaluation is a must to measure program effectiveness to increase social work competency in students." (EPAS, 2008). The Code of Ethics of the National Association of Social Workers (since 1996) emphasizes both competence (NASW Code of Ethics, 1.04) and practice evaluation (NASW Code of Ethics, 5.02) as social workers' ethical responsibilities. For instance, competence is addressed as one of important ethical responsibilities of social workers to their clients. (NASW, 1.04).

- (a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.
- (b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.
- (c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training,

consultation, and supervision) to ensure the competence of their work and to protect clients from harm

Competence is also one of the six core social work values in the ethical principle:

Social workers practice within their areas of competence and develop and enhance their professional expertise. Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession. The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective: Service, Social Justice, Dignity and Worth of the Person, Importance of Human Relationship, Integrity, and Competence

Although the description of competence is somewhat broad above, practitioners' competence is regarded as key to social work practice. Thus, a more nuanced understanding of practitioners' competence needed to be explored.

Lejonqvist et al. (2011) stated the necessity of integrating two views of clinical competence: ontological clinical competence and contextual clinical competence. Ontological clinical confidence is defined as: foundational and educational confidence that practitioners should gain during education. Contextual clinical confidence is understood as learning from experiences, deepening their knowledge and skills with possible specialties (Lejonqvist, Eriksson & Meretoja, 2011). Lejonqvist, et al. (2011) further stressed their integrated views on clinical competence with the study of clinical competence in nursing using a qualitative questionnaire (N=51). According to their study analysis by qualitative inductive content analysis, clinical competence is seen as a continuing process of "encountering, knowing, performing, maturing, and improving." which has both ontological and contextual aspects to it. This study provided invaluable

points in the meaning of competence but presented less rigor in data analysis by lacking detailed study procedures.

These integrative views of competence are also explained as foundational (ontological) and functional (contextual) competencies in the clinical field (Barlow, 2012; Boswell, Nelson, Nordberg, Mcleavey, & Castonguay, 2010). Foundational competence is knowledge-based competence containing core principles and clinical theories and knowledge obtained from formal education. Functional competence refers to applied competence containing effective performance of the necessary knowledge, skills, and values (Barlow, 2012; Boswell, et al., 2010). Considering that practitioners have already completed formal training which meets foundational competence, practitioners' competence in this study is defined as more functional competence.

Research concurs that practitioners' competence can be achieved from clinical experiences with clients (De Stefano, Atkins, Noble, & Heath, 2012; Stahl, Hill, Jacobs, Kleinman, Isenberg, & Stern, 2009; Ronnestad & Skovholt, 2003)

De Stefano et al. (2012) conducted an exploratory study of practitioners' competence on pragmatic stance. In using cross-case analysis qualitative research, the study analyzed transcribed interviews (N=12) of Master's- level counselors in training who had recently worked with at least one client who self-injured. Most of the respondents reported feelings of incompetence while working with these clients, but gained competence after they had an experience of working with this population. The study also identified the therapeutic relationship as the core competency to be implemented. In the study, "When the shoe is on the other foot: A qualitative study of

intern-level trainees' perceived learning from clients" conducted by Stahl et al. (2009), one of the emerging themes from the trainees was "felt increased sense of own competence as therapist." This theme of increased competence after working with clients occurred in the range of seven to 10 respondents (N=12).

Ronnestand & Skovholt (2003) also supported the same view in their study of "the journey of the counselor and therapist: Research findings and perspectives on professional development." With interviews of 100 American counselors/therapists at different experience levels, the study explored different phases and themes in practitioners' development. Based on their formulation of six stages of counselor/therapist development, practitioners in the experienced professional phase (Phase 5), which accounted for a number of years in clinical practice, reported to trust their professional judgments, feel competent and establish good working alliances with their clients.

Albeit rather limited, there are some research efforts in clinicians' competence and clinical outcome (Davidson, Scott, Schmidt, Tata, Thornton, & Typer, 2004; Shaw, Elkin, Yamaguchi, Olmsted, Vallis, Dobson, Lowery, Sotsky, Watkins, & Imber, 1999).

Shaw et al. (1999) were the first ones who conducted the study of the relationship between practitioners' competence and practice outcomes. They studied therapist competence ratings in relation to clinical outcome in cognitive therapy for depression. The data was based on fifty-three patients and eight cognitive behavioral therapists. The study showed rigor in data analyses by using the multiple regression analyses but conceded inconsistent positive correlations between competence and practice outcomes.

Shaw et al. interpreted that the reasons they did not have strong results was because the participating therapists had not had enough CBT training and they had used weak measures for competence ratings.

Davidson et al. (2004) conducted the randomized controlled study with the hypothesis that higher levels of therapist competence in Manual-Assisted Cognitive Therapy (MACT) would lead to better clinical outcomes. After having two days of training in MACT prior to the study and one day of training after the study had begun, the analysis of the forty-nine audiotapes of therapy sessions delivered by twenty-six therapists conceded that the level of therapist competence in delivering MACT was significantly associated with clinical outcomes. The same results were obtained at twelve-month follow-up. With a strongly randomized controlled study, the findings clearly supported a statistically significant positive relationship between competence and outcome.

Apparently, research suggests that practitioners' competence is a crucial element in practice outcome and evaluation. The importance of competence of practitioners appears to make a difference to the outcomes of the practice models. Competence itself is a function of knowledge, skills, training, and years of experience. In conclusion, practitioners' assessment of their practice is likely to be related to the proceeding factors.

Theraplay

Research suggests that a secure parent-child attachment is linked to prosocial development whereas maladaptive attachment is linked to increased aggressive child behavior (Levy & Orlans, 2000; Quierido, Bearss, & Eyeberg, 2002). It is commonly

known that the quality of the relationship between the parent and the child is crucial for the child's emotional, physical, and social development. Since foster and adoptive children often experience relational trauma (the trauma occurs in the context of other human relationships), Theraplay, which works to strengthen and promote healthy relationships, is a viable treatment modality in meeting the needs of these children.

Theraplay was first developed by Ann Jernberg and Phyllis Booth when Jernberg directed Chicago's inaugural Head Start program in 1969. In order to meet the psychological needs of children in the HeadStart programs, Jernberg and Booth built a new model to build healthy child development by incorporating elements from the work of Austin DesLauriers (DesLauriers & Carlson, 1969) and Viola Brody (1978, 1993). In the third edition of Theraplay (2010), Booth introduced Theraplay as follows:

Theraplay is an engaging, playful, and relationship-focused treatment method that is interactive, physical, and fun. Its principles are based on attachment theory and its model is the healthy, attuned interaction between parents and their children: the kind of interaction that leads to secure attachment and lifelong mental health. It is an intensive, relatively short-term approach that involves parents actively in sessions with their children in order to create or fine-tune the parent-child relationship. The effectiveness of Theraplay® springs from the use of attachment-based play to meet the needs of troubled families. Theraplay® is uniquely suited to address these needs. (Booth & Jernberg, 2010, p. xxi)

The aspects of Theraplay are emerged in its' stresses of attunement, responsiveness and empathy in the interactions between parent and child play. It believes that both privileged and underprivileged children and their parents may benefit from greater attunement to the child's developmental needs. Theraplay activities are modeled on the simple, repetitive, and healthy interactions between parents and infants. Some examples are the bean bag game, cotton ball blow, patty cake, pop the bubble, balloon

tennis, lotion print, blanket swing, paper punch, etc. Theraplay activities often become the vehicle to building healthy parent-child relationships by leading them in an attuned, responsive, and empathetic manner. Theraplay, with its emphasis on building healthy relationships through purposefully designed interactive activities, has indeed led to successful applications for foster and adopted children and their families (p. 405). Foster and adopted children who suffer from disruptions of consistent parental care, early deprivation, and trauma in their early lives can get easily reconnected and build physical and emotional closeness with their new caregivers through the Theraplay approach.

Theraplay offers parents the opportunity to build engagement skills that foster trust and open communication with their children. The four dimensions in Theraplay (structure, nurture, engagement, and challenge) helps parents provide comfort, nurture, and structure through co-regulation until the child is able to self-regulate. Theraplay helps families to enjoy spending time together while, “learning the important skill of taking turns, adapting to the other person’s rhythms, cooperating and making friends” (Booth, 2010, p. xxiii). Children learn that as their parents become more attuned and responsive, they can more reliably turn to them for emotional support and comfort and also explore their world knowing their parents’ will take steps to watch over and protect them.

Four Dimensions of Theraplay

Theraplay treatment considers four dimensions based on the needs of the child and the parent. The concepts that represent the four dimensions of Theraplay are described as follows:

- (a) Structure dimension. According to Booth and Jernberg (2010), the purpose of structure as a dimension in Theraplay is to ensure that “parents are trustworthy and predictable, and provide safety, organization, and regulation” (p. 21). Parents need to be in charge even as they attune to their children’s needs.
- (b) Engagement dimension. The purpose of the engagement dimension is learn to communicate, share intimacy, and enjoy interpersonal contact. The message is “You are not alone in this world. You are wonderful and special to me. You are able to interact in appropriate ways with others” (p. 23). Some children need to be engaged in new ways that invite them into a relationship that will provide them with more noticing and companionship than they were accustomed to seeking.
- (c) Nurture dimension. The purpose of the nurture dimension is to provide the comforting presence of a nurturing adult. The message is, “You are lovable. I want you to feel good. I will respond to your needs for care, comfort, and affection” (p. 24). Through essential nurturing activities, the child experience care, self-worth and regulation which is essential to form a secure relationship.
- (d) Challenge dimension. The purpose of the challenge dimension is to help the child experience a sense of competence. The message is, “You are capable of growing and of making a positive impact on the world” (p. 25). The child gains competency and mastery of play. Learning about appropriate challenges

is important for parents who have inappropriate developmental expectations, are overly protective, or are too competitive” (p. 25).

Seven Core Concepts of Theraplay

Understanding the core concepts of Theraplay is crucial for Theraplay treatment. These concepts are the basic guidelines for many interactions that take place in healthy parent child dyads (p. 26).

1. Theraplay is interactive and relationship-based.
2. Theraplay is a direct, “here and now” experience.
3. Theraplay is guided by the adult.
4. Theraplay is responsive, attuned, empathic, and reflective.
5. Theraplay is preverbal, social, and right-brain leveled.
6. Theraplay is multisensory.
7. Theraplay is playful.

Research on Theraplay

Most evidence for the efficacy of Theraplay is reported in case studies and clinical reports (Bennett, Shiner, & Ryan, 2006; DesLauriers & Carlson, 1969; Jernberg, 1976, 1984; Robison, Lindaman, Clemmons, Doyle-Buckwalter & Ryan, 2009). Several research studies with positive results of Theraplay are either unpublished (Morgan, 1989; Munns, Jensen, & Berger, 1997) or published in books (Talen, 2000; Zanetti, Matthews, & Hollingsworth, 2000). To date, there are only two experimental studies on the efficacy of Theraplay that are published (Sui, 2009; Wettig, Coleman, & Geider, 2011).

Sui (2009) conducted the first published experimental study to prove the efficacy of Theraplay for Chinese children with internalizing problems. Respondents of the study were forty-five children (twenty-one girls, twenty-five boys) from an elementary school in Hong Kong and their mothers (N=45). The Child Behavior Checklist (CBCL; Achenbach, 1991) was utilized to measure internalizing problems for the study. Interviews with the mothers and children were also accomplished. With the results of the univariate analyses of covariance in the study, findings suggested that Theraplay was effective on reducing internalizing problems such as shyness and anxiety in Chinese children in the Theraplay group compared to the children wait-list group. This study is not only important in that it was the first randomized study, but it also showed the applicability of Theraplay to Chinese cultures.

Wettig, Coleman, and Geider (2011) conducted two studies to assess the efficacy of Theraplay for children with language disorder and shyness/social anxiety in Germany. The first study was a controlled longitudinal study with 22 children (8 girls, 14 boys) aged 30 months to 6 years, 11 months old who were treated at a single institution by one therapist. The second study followed by 167 children (60 girls, 107 boys) aged 31 months to years to 6 years, 11 months old from a pool of 333 patients in 9 different medical centers and therapists across multiple centers to evaluate generalizability. The Clinical Assessment Scale for Child and Adolescent Psychology (CASCAP-D) (Doepfner, Berner, Flechtner, Lehmkuhl, & Steinhansen, 1999) was utilized for pre- and post-treatment and a follow-up assessment. The results supported the efficacy of Theraplay in alleviating social anxiety and improving receptive language and proved its applicability

to German cultures. The methodical limitation in the studies is that CASCAP-D seemed to be a weak measure that contained a simple rating scale (1 to 4). Also, as the authors stated, having no clinical control group was another limitation of the studies.

Theraplay is often integrated with Dyadic Development Psychotherapy (DDP), a treatment based on attachment theory. DDP practice requires “the maintenance of a contingent collaborative and affectively attuned relationship between therapist and child, between caregiver and child, and between therapist and caregiver” (Becker-Weidman, 2006). DDP emphasizes four elements of playfulness, attunement, curiosity, empathy (PACE) in practice (Hugh,2004). Despite its popularity and effectiveness among clinicians, there is only one experimental research study published in a peer review journal. Becker-Weidman (2006) conducted the study to examine the effectiveness of Dyadic Developmental Psychotherapy (DDP) with thirty-four foster and adopted children aged five to sixteen years old in the treatment group and thirty children in the control group who all have trauma-attachment disorder, met the DSM-IV criteria for Reactive Attachment Disorder, and had histories of serious maltreatment. Findings suggested the efficacy of DDP for children with trauma-attachment disorders. As measured by the Randolph Attachment Disorder Questionnaire (RADQ) and the Child Behavior Checklist (CBCL), children in the treatment group experienced significant decreases ($p<.01$) in symptoms of attachment disorder, withdrawn behaviors, anxiety and depression, social problems, thought problems, attention problems, rule-breaking behaviors and aggressive behaviors. Although this study’s result are limited by institution and therapist-specific effect (one therapist at one setting provided DDP to one treatment group), it is a good

pioneer study in exploring attachment-based intervention in treating foster and adopted children.

Although research studies on Theraplay are not sufficient, the Theraplay approach is widely spread in social work practice. For instance, Integrative Attachment Therapy Program (IAT) at Chaddock, a nationally accredited residential agency in Quincy, IL, also well depicts the successful use of Theraplay. Unlike other traditional residential care programs that emphasize behavior modifications, Chaddock incorporates Theraplay and DDP with the goal of maximizing relationship development. The staff at Chaddock found that Theraplay is effective in building a secure relationship with children and adolescents and saw great efficacy of its use in combination with DDP in treatment (Doyle-Buckwalter & Robinson, 2005). More importantly, Theraplay is currently recognized as a promising practice for children and adolescents in child welfare by the California Evidence-Based Clearing House Review (2009).

This study further explored the use of Theraplay as an effective tool in serving foster and adoptive children and families. In particular, this study is intended to explore therapists' evaluation of whether Theraplay applications are effective and how its applications are practiced. Additionally, this study may offer the preliminary step for identifying therapeutic elements in Theraplay that may help foster and adoptive children and their families.

Chapter III presented a literature review pertinent to mental health needs in foster and adopted children, practitioners' competency, and the applicability and evidence for Theraplay for this population. Understanding research gaps in clinical practice for foster

and adopted children and their families, the existing literature clearly bolsters the need to explore the practitioners' evaluation of Theraplay.

CHAPTER FOUR

METHODOLOGY

This chapter outlines research designs and methods applied in this study. This chapter (1) explains a rationale for using a mixed method research design in this study, (2) describes the survey design, (3) illustrates case study, (4) presents focus groups, and (5) concludes with ethical considerations and limitation. For each of research methods used and listed above, sample design, instrument development process with reliability and validity test, pilot test, and inter-rater reliability test for coding theme in measuring competency, and data analysis procedures are explained.

Research Design

A mixed-method research design was selected for this study because it best answers the study's research questions with higher response rates and provided an in-depth exploration in this study (Groves, Fowler, Couper, Lepkowski, Singer, & Tourangeau, 2004). The study has three components: survey design, case study, and focus groups. By collecting and analyzing the data using multiple modalities, the researcher was able to explore practitioners' evaluations of Theraplay in-depth. Creswell & Plano Clark (2007) stated that a mixed-method research helps the researcher to maximize the benefits of each approach by using the strengths of the other. By employing the mixed-method research design, important perspectives are gained that would not be obtained with one method or the other (Greene, 2008). The primary reason that the

researcher chose qualitative methods for this study was to add depth to the survey research (Patton, 2002). By conducting case studies and focus groups based on survey questions, the researcher planned to explore and construct the in-depth meaning of the relationship between practitioners' competence and Theraplay practice/evaluation. Additionally, the use of a mixed-mode design facilitated a convenient and accessible participant recruitment and assessment process. While gathering responses, the respondents' different preferences were considered, as some practitioners preferred self-administered survey, while other practitioners preferred to talk about it in a focus group setting.

The survey instrument was distributed to all Theraplay-trained respondents who attended the 6th Theraplay International Conference in Evanston, IL from July 11 to July 12, 2013. In the survey design, the researcher did not manipulate an independent variable; therefore, there is no concern of manipulation checks (Heppner, Wampold, & Kivlighan., 2008). The ease of data collection was one of the advantages of using a survey (Heppner et al, 2008), especially when the survey instrument was distributed at the conference site. The researcher directly distributed the survey from 8:00 a.m – 8:30 a.m and then collected the survey at 5 p.m. on each conference day. Potential disadvantages for using a survey study with low responses rates (Heppner et al., 2008) were complemented by collecting qualitative data from focus groups at the same time. The nineteen focus group participants were recruited on the first day of the conference during registration. One focus group was conducted per conference day, totally two groups. Lastly, the researcher emailed to twenty-six practitioners who provided email

address and was able to gather five cases description using Theraplay. One case was selected for this study because the rest did not meet the recruitment criteria of describing cases for either foster or adopted child. A visual depiction of the current mixed-method design is outlined in Figure 2.

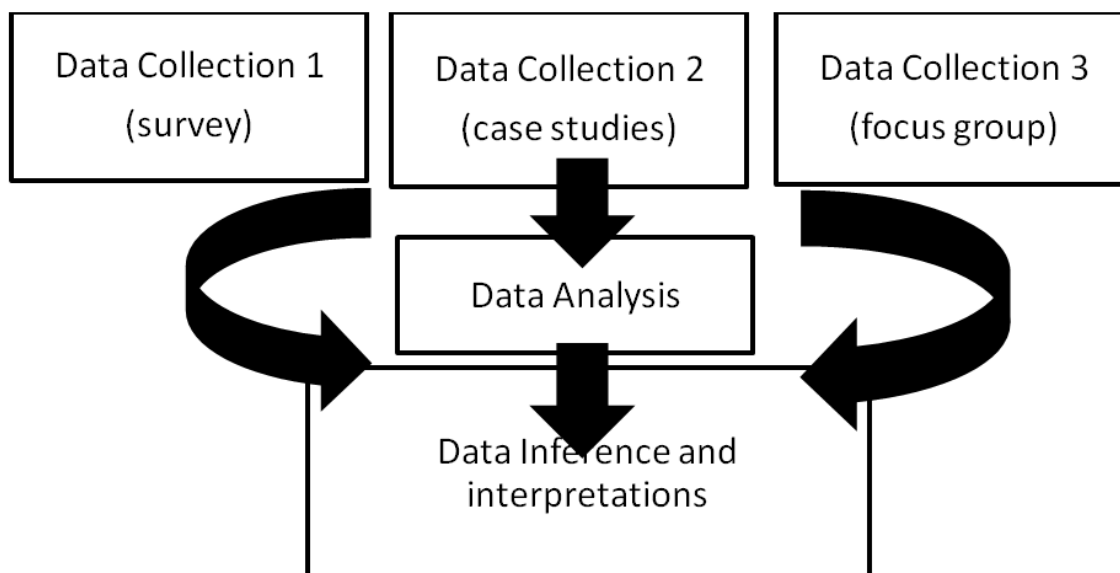


Figure 2. Mixed Method Design Diagram

Sample

After gaining approval from the dissertation committee and the Institutional Review Board (IRB) of Loyola University Chicago, the researcher proceeded with the recruitment of respondents through the Theraplay Institute in Evanston (Theraplay's international headquarters). The researcher first contacted Ms. Gayle Christensen, executive director of the Theraplay Institute (TTI) to plan the recruitment during the international conference. TTI agreed to provide the survey booth near the registration desk and to arrange a room for the focus groups.

The sampling frame for the study was the attendees (N=230) of the 6th International Theraplay Conference held in Evanston, IL on July 11- 12, 2013. During the conference, the researcher set up a booth to distribute and collect the surveys near the registration desk. The researcher directly distributed the survey from 8:00 a.m – 8:30 a.m and then collected the survey at 5 p.m. on each conference day. The consent form containing information about ethical considerations such as benefits, risks, and voluntary participation was placed at the beginning of the survey. A copy of the consent form is located in Appendix A.

The survey administration was conducted in the following manner in an attempt to increase responses and prevent possible errors (Mertens, 2010): (a) the researcher formally announced the research study at the Theraplay trainers' meetings on July 10 in order to increase awareness of survey administration during the conference dates and the researcher set the survey booth near the registration booth at 7:30am on July 11 in order to gain more attention for survey participation with the poster explaining the survey goals hung next to the booth, (b) the Theraplay Institute staff included the survey in the registration package, (c) the box to collect the completed surveys was placed on the table, and (d) the researcher remained in the booth during the break and at the end of the conference to provide any necessary assistance.

Instrument Development Process

The survey instrument was constructed by the researcher in consideration of Theraplay practice principles (see Appendix C). After constructing the survey and

designing the questions, the researcher conducted pilot tests with three people who were trained in Theraplay and then made necessary changes to improve the instrument.

Conceptualization of the Instrument

The survey was comprised of four parts: (1) Part 1 – “Theraplay in Practice” with eleven Likert-type rating scale responses, (2) Part 2 – “Theraplay Competency” with a case vignette and five open-ended responses (3) Part 3 – “Professional Characteristics” with four closed and two open-ended responses, and (4) Part 4 – “Personal Characteristics” with five close-ended responses.

Dependent variables. *Theraplay in Practice.* The treatment sessions using Theraplay practice process contain Theraplay dimensions, core-concepts, skills, and attachment-based knowledge. Operationally, it pertained to the survey questions 1-9 in Part I. The practitioners were asked to rank order the questions according to their preference and practice in questions 1- 9 in Part I. Also, for the purpose of this study, “the practitioners’ evaluations of the use of Theraplay” mean Theraplay-trained practitioners’ beliefs of Theraplay as an effective tool in serving the needs of children and families in the child welfare system. The perceptions of practitioners were measured by questions 10 and 11 in Part I.

Independent variables. *Personal characteristics.* Five questions in Part IV were measured for personal demographics.

Professional characteristics. Six questions in Part III were measured for professional demographics.

Operationalization of the Instrument

The first part contained eleven questions regarding Theraplay practice with a Likert-type 1-10 scale in which 10 means the most frequently used and 1 means the least frequently used. The second part measured Theraplay competence and contained five open-ended questions responding to the case vignette. Part III was comprised of six questions of professional characteristics:

1. Professional affiliation: *social work = 1, counseling =2, psychology =3, family and marital therapy =3, child development =4, others =5*
2. Highest degree completed: *bachelor's degree =1, master's degree=3, Ph.D/or doctoral degree=3*
3. Level of Theraplay training: *completed introductory and intermediate training =1, Level 1 practitioner (introductory training +8 supervised sessions) and Level 2 practitioner (introductory and intermediate training and 20 supervised sessions and a passed mid-term = 2, certified Theraplay therapist and certified Theraplay supervisor =3*
4. Number of years in clinical practice: *0 to 2 years =1, 3 years to 7 years =2, 8 years to 15 years =3, 16 years above =4*
5. Number of years in Theraplay practice: *0 to 2 years =1, 3 years to 7 years =2, 8 years to 15 years =3, 16 years above =4, and*
6. Population served: *adopted children/families =1, foster children and families =2, reunification cases =3, domestic violence cases =4, relational problem with biological children=5, others =6*

The last part was comprised of four personal characteristics:

1. Age: 20-29=1, 30-39=2, 40-49 =3, 50-59 =4, 60-69 = 5, 70 over=6
2. Gender: *male* =1, *female*=2, *other* =3
3. Country to practice: *U.S.* =1, *Korea* =2, *Canada*=3, *Hong Kong*=4, *Austria* =5, *Kenya* =6, *Italy* =7, *Denmark* =8, *Japan* =9, *Israel*=10, *Latvia* =11, *Sweden*=12, *Finland*=13, *England* =14
4. Ethnicity: *Caucasian* =1, *Korean*=2, *Japanese* =3, *Chinese*=4, *Canadian*=5, *African*=6, *Australian*=7, *Jewish* =8, *Latina*=9, *Italian* =10, *Danish* =11, *Swedish*=12, *Latvian* =13, *Finnish* =14, *Others* =15
5. Marital Status: *single* =1, *married* =2, *divorced* =3, *other* =4

Lastly, there was an optional dichotomous (yes-no) question for asking an email address to gather descriptions of case using Theraplay. The researcher emailed to recruit descriptions of cases using Theraplay for those who supplied their email addresses two weeks after the survey was conducted.

Measurement of the Instrument

Survey pilot test. A survey pilot study was conducted prior to administering the survey instrument in order to insure its accessibility and respondents' understanding of the questions (Fowler, 2002). The researcher recruited four people who met the research inclusion criteria for the pilot study: one certified Theraplay therapist, one Level 2-trained Theraplay therapist, and two Level 1-trained Theraplay therapists. By adapting the recommendations of Lancaster, Dodd, Williamson(2004), the following procedures for pilot study were employed.

First, the researcher distributed the survey instrument to four respondents at the same time and recorded the start and end time. It took an average of fifteen minutes to complete the survey instrument. No one asked for clarifications of the questions. Secondly, after the survey was completed, the researcher had a debriefing time with the four respondents together to explore whether the respondents understood the questions clearly. The respondents reported the easiness of Part I, Part III, Part IV, but felt somewhat burdened while completing Part II (Theraplay Competency Measures). Comments for Part II (Theraplay Competency Measures) were 1) not enough information about the case vignette and 2) longer time to answer questions. The researcher reviewed the comments with the other coder who participated in developing themes for Part II but decided not to make any modifications considering its purpose of measuring competency. Finally, the researcher's academic chair provided input and recommendations for response scales prior to administering the survey to the target population.

Inter-rater reliability test for coding. Considering inter-rater reliability of the measure, the responses were measured by following the coding themes designed by two coders (the researcher and a certified Theraplay therapist/supervisor¹) (see Appendix E). The second coder is a highly skilled and prominent Theraplay practitioner and trainer who is internationally recognized in Theraplay community. The coders met and developed coding themes for each question, using a 0-3 scale. For questions 1, 2, 4, there were three components for each in which 0 meant nothing was correct, 1 meant one

¹ The coder is Sandra Lindaman who is a certified Theraplay therapist, supervisor, and trainer. She is the current training advisor at the Theraplay Institute (TTI). Being a certified Theraplay therapist, supervisor and trainer means that she holds the highest competency in Theraplay practice and training

component was correct, 2 meant two components were correct, 3 meant all three components were correct. For question 3, there were two components and the rating was designed as shown in Table 1.

Table 1. Inter-Rater Reliability Rating Sheet for Part II, Question 3

Points	Themes
3	Nurture/engagement or nurture/engagement/structure
2	Structure/engagement
1	Structure/challenge or structure/nurture or engagement or nurture
0	Structure or challenge

The two coders met at the Theraplay Institute on September 8, 2013 to conduct the inter-reliability check for coding for the responses in Part II based on the themes developed. The coders agreed to measure questions 1 to 4 because question 5 did not support the criteria to measure the practitioners' competency. The inter-rater reliability check was done with the following steps: first, the coders would conduct inter-rater reliability check for the first randomly selected ten surveys. If the results of inter-rater reliability check for the first ten surveys yielded less than 60 %, then the second set of ten surveys would be randomly selected. If the second set of ten surveys were to again yield less than 60%, then two coders would have to code them all together. The first selected ten surveys were: #74, #21, #20, #72, #39, #81, #73, #69, #55, and #56. The researcher took the first five and the other coder took the rest. Once they completed coding the five, they exchanged and continued to code the other five surveys (see Appendix E).

Reliability and validity test. Since the instrument was developed by the researcher, a scale reliability test was conducted to estimate Cronbach's "alpha", which determines justifiable reliability of dependent variables in the instrument. Hagan (2003) stated, "Consistency of measurement is determined by whether the set of items used to measure some phenomenon are highly related (associated with each other) and measuring the same concept" (p. 280). As such, Cronbach's alpha was used for the determination of internal consistency of measurement and/or reliability.

As for internal consistency, Cronbach's alpha coefficient about 11 dependent variables (questions 1-11) was estimated as .871. In the social sciences research, Cronbach's alpha, which is greater than .70, is considered acceptable; and an alpha greater than .80 is preferred and is considered to have "good reliability."² Thus, the scale sets of having an alpha of .871 for this instrument was considered to have "good reliability."

Regarding competency scales measure, inter-rater reliability a multiple rater Cohen's Kappa coefficient (K) was calculated for two coders, in addition to percentage agreement. Kappa is commonly used as a measure of inter-rater reliability among coders when there are a few categories with a small sample size. In order to measure inter-rater reliability in competency measure, the researcher and the coder randomly first selected 10 survey cases out of 87 and gained 87.5 percentage agreement (see Appendix E). Secondly, Kappa was calculated because it is equal to the proportion of agreement actually observed between raters, after adjusting for the proportion of agreement expected

² Chronbach's alpha is the most commonly used measure of reliability (i.e., internal consistency) (Chronbach, 1951).

“by chance” (randomly) (Cohen, 1960). A Kappa (K) of $>.70$ is considered acceptable inter-rater reliability, a K of 0.40 to 0.59 is moderate inter-rater reliability; a K of 0.60 to 0.79 substantial; and a K of 0.80 is outstanding.

As outlined in Table 2, the inter-rater coefficients and percentage agreement among two coders for competency measure revealed strong agreement with outstanding ($K=.808$; percentage agreement= 87.5).

Table 2. Inter-Rater Reliability and Percentage Agreement for Competency Measure

Code	Kappa	% agreement
Competency scale measure	.808	87.5

The researcher considered the instrument’s threats to validity. In general, validity refers to accuracy in research. A study can be internally valid if extraneous variables (history, maturation, testing effects, instrumentation, statistical regression, differential selection, experimental mortality, selection –maturation interaction) are controlled (Merton, 2010, p.127).

In this study, the researcher attempted to minimize testing effects by encouraging honest feedback on the survey and by administering the instrument only once to avoid instrument errors. The researcher further tested construct validity of various sections of the instrument. Finally, a pilot study was conducted to ensure the integrity of the survey implementation.

Sample Design

Mixed methods sampling, specifically identical-nested sampling (Merton, 2010), was used for this study because a subset of respondents in the survey study were chosen

again to participate in focus groups. An identical nested sampling refers to the use of two different methods using the same samples at the same time (Merten, 2010). The researcher conducted both survey research and focus groups with the Theraplay-trained mental health professionals who attended the 6th International Theraplay Conferences.

Using an identical nested sampling, this study can achieve many benefits. First, the researcher can precisely interpret and explore the meaning of the data collected from the survey with the data obtained from the focus group. Secondly, it has cost benefits because the researcher can save time and money by collecting the data at one site. However, this undertaking can unravel a concern of sampling bias. Henry (1990) states the risk of non-probability-based sampling because sampling bias might occur, adding uncertainty to the sample's representativeness. Thus, it was determined to collect the data during the international conference in order to obtain representativeness from practitioners from twenty-nine different countries where Theraplay is practiced (Booth & Jernberg, 2010, p. xii). This allowed the researcher to obtain a more representative sample of the population who practice Theraplay nationally and internationally.

In order to determine the inclusion criteria for this study, the researcher defined Theraplay-trained mental health professionals as those who received Theraplay training from the Theraplay Institute (TTI). Specifically, TTI certification protocols were the base for inclusion criteria. TTI currently offers five certificates: 1) Level 1 practitioner for those who attend Level 1 Theraplay training and have 8 supervised sessions from a total of 40 Theraplay sessions; 2) Level 2 practitioner for those who attend Level 1 and Level 2 Theraplay training and have 20 supervised sessions from a total of 100 Theraplay

sessions and pass a mid-term; 3) certified Theraplay therapist for those who complete an additional 17 supervised sessions from an additional 100 Theraplay sessions and pass a final; 4) certified Theraplay supervisors for those who supervising four practitioners and are certified Theraplay therapists. Finally, there are certified Theraplay trainers, but I will exclude them in this study because all of the trainers are certified Theraplay therapists and many are certified Theraplay supervisors.³

Therefore, the inclusion criteria for this study were: a) an attendee of the 6th International Theraplay Conference, b) have earned at least a bachelor's degree, and c) at least completed introductory Theraplay training. If the respondents failed to comply with any of these three criteria, their survey responses were excluded from the data. Such inclusion criteria was vital for the purpose of increasing validity and reliability because it provided the researcher with reliable subjects. The respondents for this survey consisted of 87 Theraplay trained mental health practitioners. The data for personal and professional characteristics were described below.

Personal Characteristics: Age, country of practice, ethnicity, and marital status. Of the 87 completed responses, 78.2 % (N=68) were females; 9.2 % (N=8) were males; 12.6 % (N=11) did not report their gender, 74.7% (N=65) were married; 16.1 % (N=14) were singles; 6.9 % (N=6) were divorced; 2.3 % (N=2) did not report their marital status, 66.7 % (N=58) practiced in United States; 8.0 % (N=7) practiced in Korea; 5.7 % (N=5) practiced in Japan; 2.3 % (N=2) practiced in Canada; 3.4 % (N=3) practiced in Australia; 2.3 % (N=2) practiced in Denmark; 1.1 % (N=1) practiced in Israel; 1.1%

³ Adapted from Theraplay certification procedures at the Theraplay Institute (TTI).

(N=1) practiced in Italy; 1.1 % (N=1) practiced in Finland; 1.1 % practiced in Kenya; 1.1 % (N=1) practiced in Sweden; 1.1 % (N=1) practiced in Latvia; 1.1 % (N=1) practiced in Hong Kong; 1.1 (N=1) did not report the country to practice, 62.1 % (N=54) were Caucasian; 9.1% (N=8) were Korean; 5.8% (N=5) were Japanese; 2.3 % (N=2) were Canadian; 2.3 % (N=2) were Australian; 2.3 % (N=2) were Danish; 2.3 % (N=2) were Chinese; 1.1 % (N=1) was Israelite; 1.1 % (N=1) was Italian; 1.1 % (N=1) was Finish; 1.1 % (N=1) was Swedish; 1.1 % (N=1) was Latvian; 9.1 % (N=1) did not report their ethnicity, and 32.2 % (N=28) were ages ranged from 50 to 59; 26.4 % (N=23) were ages ranged from 30 to 39; 19.5% were ages ranged from 40 to 49; 16.1 % were ages ranged from 60 to 69; 4.6% were ages ranged from 20 to 29; and 1.1 % (N=1) were ages ranged from 70 over (see Table 3).

Professional Characteristics: Professional affiliation, degree, level of Theraplay training, years in clinical practice, and years in Theraplay practice. Of the 87 completed responses, 34.5% (N=30) were counselors; 24.1 % (N=21) were social workers; 17.2 % (N=15) were psychologists; 12.6 % (N=11) were Family and Marital Therapists; and 6.9 % (N=6) were child developmental specialists; 4.6 % (N=4) reported as being “others”, 73.6 % (N=64) had obtained a master degree; 16.1 % (N=14) had obtained a Ph.D. or equivalent degree; 8.0 % (N=7) had obtained a bachelor degree; 2.3 % (N=2) did not report their highest degree, 44.8 % (N=39) were completed Introductory or Intermediate or training ; 33.3 % (N=29) were certified Theraplay therapist or supervisors; 14.9 % (N=13) were level 1 or level 2 practitioner; and 6.9 % (N=6) did not report their level of Theraplay training, 29.9 % (N=26) had 16 years over in clinical

Table 3. Summary of Personal Characteristics (N=87) for Country of Practice, Ethnicity, Gender, Marital Status, and Age

Country	#	%	Ethnicity	#	%	Gender	#	%	Marital status	#	%	Age	#	%
U.S.	60	68.9	Caucasian	54	62.1	Male	8	9.2	Single	14	16.1	20–29	4	4.6
Korea	7	8.0	Korean	8	9.1	Female	68	78.2	Married	65	74.7	30–39	23	26.4
Japan	5	5.7	Japanese	5	5.7	Missing	11	12.6	Divorced	6	6.9	40–49	17	19.5
Canada	3	3.4	Canadian	2	2.3				Others	2	2.3	50–59	28	32.2
Australia	2	2.3	Australian	2	2.3							60–69	14	16.1
Denmark	2	2.3	Danish	2	2.3							70+	1	1.1
Others	7	8.0	Chinese	2	2.3									
Missing	1	1.1	Others	11	13.5									
			Missing	1	1.1									

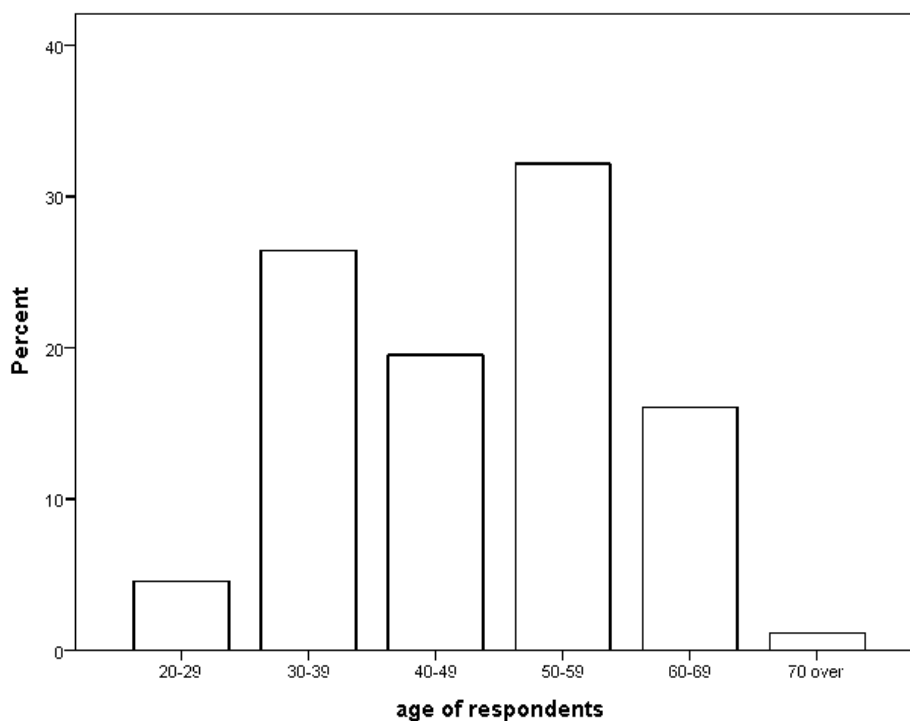


Figure 3. Histogram of Age of Respondents

practice; 26.4 % (N=23) had 3 to 7 years in clinical practice; 23% (N=20) had 8 to 15 years in clinical practice; 12.6 % (N=11) had 0 to 2 years in clinical practice, and 8% (N=7) did not report their years of clinical practice, and 29.9% (N=26) had 0 to 2 years in Theraplay practice; 25.3 % (N=22) had 8 to 15 years in Theraplay practice; 23% (N=20) had 3 to 7 years in Theraplay practice; 8% (N=7) had 16 years over in Theraplay practice; and 13.8% (N=12) did not report their years of Theraplay practice (see Table 4).

Data Cleaning Approach

Out of 220 surveys distributed, 88 survey responses were collected over the two day conference. In order to detect and remove errors and to prepare accurate and consistent data, the researcher first conducted the following data cleaning process:

1. each survey response was given a number at the top of the survey in order to prepare for data entry,
2. the researcher went through eighty eight survey responses and removed one survey that had left all items blank except for two items in the personal characteristics category.
3. the researcher named the variable measures such as nominal, ordinal, and scale based on each variable,
4. twenty-eight variables from the survey were first entered in SPSS 22,
5. Part II (Practitioners' Competency) inter-rater reliability check was conducted with the researcher and the other coder (certified Theraplay therapist and supervisor).
6. the researcher coded the other seventy seven surveys independently and obtained five variables from Part II such as competency of goals for the child, competency of goals for the parents, competency of two dimensions, competency of session plans, and the sum of competency scales,
7. the researcher entered five more variables related to Part II in SPSS 22. Thus, there were thirty-three variables in SPSS 22,
8. the researcher entered all variables in SPSS 22,
9. the researcher used the frequencies in descriptive statistics in SPSS 22 to identify errors in data entries. The researcher was able to identify mistyped numbers in some entries, and finally
10. the researcher checked the SPSS data entries three times and corrected them for missing data and coding errors

Table 4. Summary of Professional Characteristics data (N=87) for Professional Affiliation, Degree, and Level of Theraplay Training

Professional affiliation	#	%	Highest degree	#	%	Level of Theraplay training	#	%	Years clinical	#	%	Years Theraplay	#	%
Social work	21	24.1	Bachelor	7	8.0	Intro/ intermediate	39	44.8	0–2	11	12.6	0–2	26	29.9
Counseling	30	34.5	Master	64	73.6	Levels 1 & 2	13	14.9	3–7	23	26.4	3–7	20	20
Psychology	15	17.2	PhD	14	16.1	Certified/ supervisor	29	33.3	8–15	20	23	8–15	22	25.3
Family therapy	11	12.6	Missing	2	2.3	Missing	6	6.9	16+	26	29.9	16+	7	8.0
Child development	6	6.9							Missing	7	8	Missing	12	13.8
Others	4	4.6												

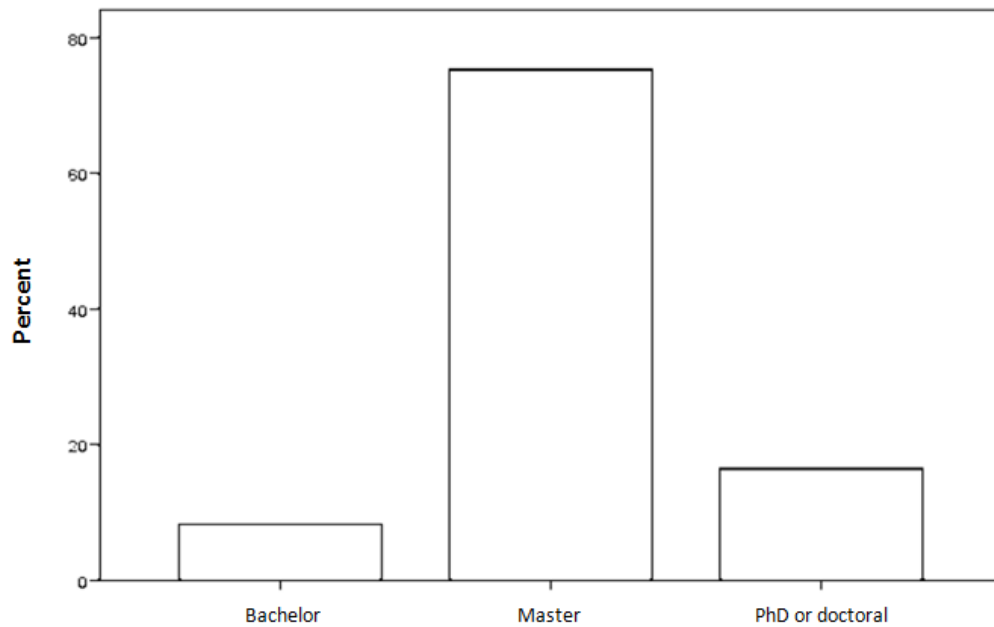


Figure 4. Histogram of Highest Degree Completed

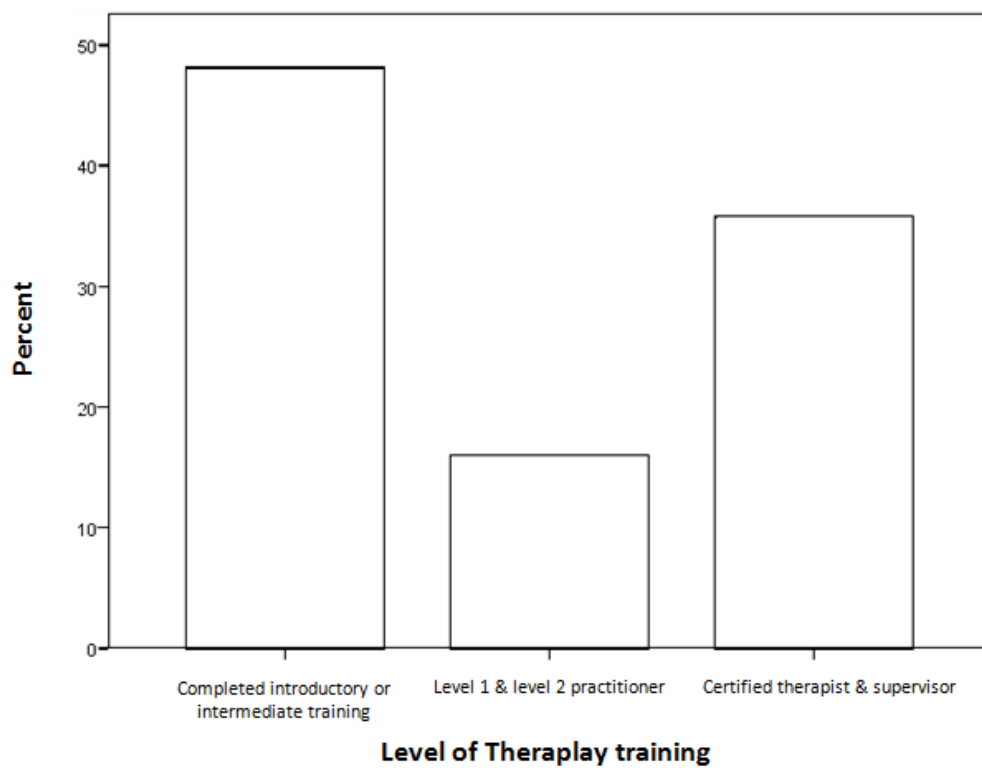


Figure 5. Histogram of Level of Theraplay Training

Figure 6 depicts the five parts of the survey instrument.

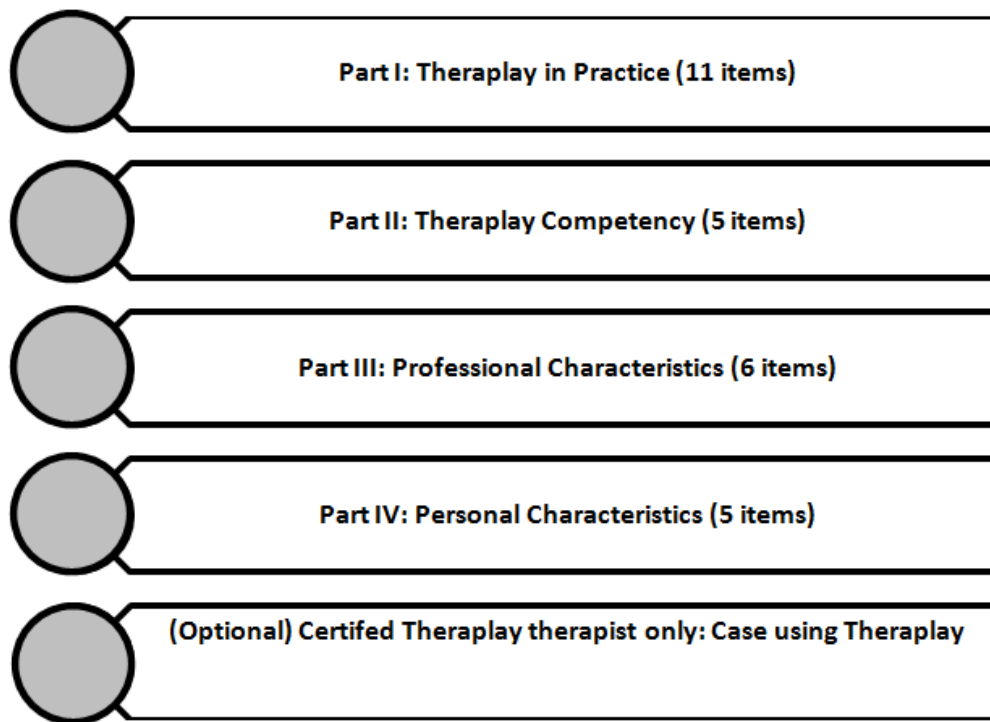


Figure 6. Survey Questionnaire

Additional survey methodological considerations were employed to increase the rigor of the instrument design, such as:

1. the survey questionnaire about Theraplay practice was reviewed and approved by a training advisor at the Theraplay Institute,
2. the survey contained the confidentiality of respondents, the right to stop at any time, and their voluntary participation,
3. the survey design was simple with a total of twenty-seven variables and used the languages familiar to the Theraplay-trained practitioners,
4. the survey design contained adequate spacing and visual cues such as bold face type and underlines to make it easy to read and visually appealing.

5. typical case descriptions were used to measure Theraplay competence.

Data Analysis Procedures

In order to determine the best statistical test, the researcher must scrutinize research questions. Mertler & Vannatta (2004) suggested organizing four different types of researcher questions: “degree of relationship among variables, significance of group difference, prediction of group membership, and structure” (p.13). Based on this classification, the responses scales were analyzed using descriptive statistics, factor analysis, one-way ANOVA F-tests, and Pearson’s correlation analysis. More specifically, the following procedures were implemented:

Descriptive statistics. The study first examined descriptive statistics such as personal characteristics (age, gender, country to practice, ethnicity and marital status) and professional characteristics (professional affiliation, highest degree earned, years of clinical practice, years of Theraplay practice, and level of Theraplay training). Frequencies, percentages and, and central tendencies (mean, mode, standard deviations) were calculated for personal and professional characteristics. Furthermore, crosstab analysis was performed to see how the dependent variable (effectiveness of Theraplay) varied in relation to the independent variables (Level of Theraplay training and Practitioners’ competency).

Principal component factor analysis. Factor analysis is usually defined as a procedure used to determine the extent into which measurement overlap exists among a set of variable (Williams, 1992). It allows the researcher to determine if measures for different variables are measuring something in common. In other words, it is used to find

orthogonal factors that make up the dependent variables and to reduce the mass of data to a more manageable amount. After identifying “factors”(the groupings of variables that are measuring some common construct)” in the scale, researchers are able to see factor loading which is simply a correlation coefficient and shows the extent to which an item is measuring that factor. In sum, factor analysis is an essential process to reduce variables by determining which variables cluster together (Mertler & Vannatta, 2004). For this study, the principal components factor analysis was used to explore factor loading for further analyses of one-way ANOVA F-tests. The researcher performed one factor analysis with eleven dependent variables (Theraplay practice) to identify representative dependent variables to be used in one-ways ANOVA analyses.

Correlations coefficients. Correlation analysis was used to explore correlations between variables. The researcher performed Spearman correlation between level of Theraplay Training and effectiveness of Theraplay because the data has some non-linear component and the variables are ordinal. Also Pearson’s correlation were used to describe the strength and direction of the linear relationships between other variables (years in Theraplay practice, level of competency, and effectiveness of Theraplay).

Specifically, the researcher performed the following correlations:

- Spearman’s Correlation between level of Theraplay training (IV) and effectiveness of Theraplay (DV)
- Pearson’s Correlation between years in Theraplay practice (IV) and effectiveness of Theraplay (DV)

- Pearson's Correlation between the sum of practitioner's competency (IV) and effectiveness of Theraplay(DV)

Table 5 was the guide for the interpretation of correlation coefficient.

Table 5. Interpretation of Correlation Coefficient

Coefficient		Interpretation
Spearman <i>rs</i>		<i>rs</i> of 0.9 to 1, the correlation is very strong.
		<i>rs</i> between 0.7 and 0.89, correlation is strong.
		<i>rs</i> between 0.5 and 0.69, correlation is moderate.
		<i>rs</i> between 0.3 and 0.49, correlation is moderate to low.
		<i>rs</i> between 0.16 and 0.29, correlation is weak to low.
		<i>rs</i> below .16, correlation is too low to be meaningful.
Pearson <i>r</i>	Small	$r = .10$ to $.29$
	Medium	$r = .30$ to $.49$
	Large	$r = .50$ to 1.0

Note. Interpretation of Correlation Coefficient (Cohen, 1988, p.79-81).

Lastly, the scatterplots were accompanied to check the distribution of the variables.

One-way analysis of variance. One-way analysis of variance (ANOVA) is used when researchers are interested in comparing the mean scores of more than two groups (Pallant, 2011, p. 249). ANOVA compares the variance between the different groups with the variability within each of the groups. Since this researcher compared the mean value of one independent variable (level of Theraplay training) and one dependent variable (effectiveness of Theraplay) in this study, a one-way ANOVA was used to investigate the differences. In particular, one-way between-groups ANOVA was used because the independent variable (level of Theraplay training) has three levels and one dependent variable (effectiveness of Theraplay) is continuous variable. One-way between-groups

ANOVA was suitable to explore the researcher question of “Is practitioners’ Theraplay practice associated with their evaluation of Theraplay?” The researcher explored whether there was significant differences in the mean scores on the dependent variable across the three levels of Theraplay training. Post-hoc tests were then used to find out there these differences lay.

There are three underlying assumptions in using one-way ANOVA: (1) Homogeneity of variance – it refers to the variance for each group being equal to the variance of every other group. In other words, the variance of each group is equal to the variance of the error for the total analysis because heterogeneous variance can greatly influence the results the researcher obtain, making it either more or less likely that the researcher would reject H_0 , (2) Normality – its procedures assumes that scores are normally distributed, meaning that errors are normally distributed, (3) Independence of observation – it means that the scores for one group are not dependent on the scores for another group, and (4) Linearity –the relationships between two variables should be linear (p.126).

Case Study

As a qualitative approach, case study research is popular and accepted due to its accessibility as an “easy- to-apply approach” to studying human interests (Taylor & Francis, 2013). Despite some reservations as to whether case study research constitutes a methodology (Sake, 2000), researchers have accepted case study research as a statistically valid research strategy, especially in mixed-methods where data findings

were integrated as words and numbers (Creswell, 2011). As such, this researcher conducted case study research as part of mixed-methods.

Sampling

The researcher sent emails to the participants requesting descriptions of cases using Theraplay for survey respondents who supplied their email address at end of survey. Twenty-six people supplied their email address and agreed to provide descriptions of cases using Theraplay. The researcher emailed twice but only obtained 5 cases from 3 people. However, only 1 case was selected because 4 cases did not describe foster or adopted cases. Table 6 shows the characteristics of the practitioner who provided cases.

Table 6. Characteristics of the Practitioner Who Provided a Case

Characteristic	Practitioner
Age	52
Gender	Female
Marital status	Married
Country to practice	USA
Professional affiliation	Counseling
Highest degree completed	Master's degree
Level of Theraplay training	Level 1 practitioner
Years in practice	4 years

In order to obtain the case descriptions, the following instructions were emailed to the respondents:

In your description of cases using Theraplay, include the following: age, gender, ethnicity, diagnosis, length of Theraplay (number of sessions), level of parents' involvement in Theraplay, a typical Theraplay sequence, and your measurement of treatment success.

1. Please describe your most successful case using Theraplay
2. Please describe your least successful case using Theraplay

Undertaking a case study research requires addressing clinical biases, therefore while requesting a case summary, this researcher (Taylor & Francis, 2013; Yin, 2009): (1) developed the questions with the intentions to explore practitioners' perspectives as to what works and how it works in Theraplay, (2) prepared to explore the content to see how the researcher's thoughts and insights flowed in reviewing and analyzing the case description, (3) met with the peer researcher⁴ who was a Level 1 Theraplay practitioner and possessed vast understanding of qualitative research, and (4) explored the cases with the peer researcher and conducted "memoing": reading, thinking, and making notes as part of the case analysis.

Data Analysis Procedures

Qualitative content analysis was used to examine the case study. The analysis began with inductive data analysis process with more of an emphasis on inferences and reflections by grouping themes and subthemes. Specifically, the following steps were employed.

This process of becoming intimately familiar with the phenomenon under the case (Eisenhardt, 2002) helped the researcher review the case description with open coding by line approach to identify gerunds, impressions, key points, etc. (Corbin & Strauss, 2008). By checking line-by- line through the data, the researcher and the peer researcher were able to merge the thoughts and stories of the cases. This generated an in-depth

⁴ Mee-hi Jeon is a doctoral student at Counseling Department in Northern Illinois University (NIU). She is trained in Theraplay and also holds a certification in qualitative research methodology at NIU.

understanding and description of case (Eisenhardt, 2002) and allowed the researcher to examine what worked and how it worked in Theraplay.

Next, the researcher began coding which refers to categorizing data. The researcher categorized the data by identifying which open codes appeared more frequently in the text. The set of categories helped to identify the core variables (themes) and the less prominent variables (subthemes) (Corbin & Strauss, 2008). In this way, the researcher developed the descriptive analytical framework. The researcher took notes for intuiting and analytical reflections during this process.

Finally, the researcher re-ordered the data to explain the relationships involved in the themes. While identifying themes, the researcher began to compile a conditional matrix to track the development of themes and subsequent themes. The researcher made sure there was consistency across the analysis by moving back and forth between the open coding and the closed coding (Corbin & Strauss, 2008).

Focus Group

Focus groups refer to carefully planned group interviews on the topic of interest (Langford & McDonagh, 2005). Researchers view focus groups as a qualitative research method designed to generate and collect data in a group discussion with an emphasis on the interactions or “synergy” between the respondents within the group (Tayler & Francis, 2013; Mertens 2010; Langford & McDonagh, 2005; Krueger & Casey, 2009). Focus groups offer a multidimensional data collection venue (Creswell, 2013) with the opportunity to share and build knowledge and experiences within a group format. Focus groups result in “knowledge development” with “active and contextual, unfolding as the

group process unfolds” (Krueger & Casey, 2009) which makes group data collection methods ideal for qualitative interpretive methods (Krueger & Casey, 2009). Langford & McDonagh (2005) stated the purpose of focus groups as follow (p. 2):

- obtaining general background knowledge for a new project, thus guiding the development of more detailed research, for example, the design of questionnaires;
- evaluating or gaining understanding and insight into result from other related research;
- gaining impressions and perceptions of existing or proposed services, products, programs, or organizations;
- stimulating new ideas or concepts.

This researcher chose focus groups for two of the reasons above: (1) gaining understanding and insight into results from survey research and (2) gaining practitioners’ perceptions, insights, beliefs, and experiences of Theraplay while working with foster and adopted children and families. In addition, focus group research has the advantage of obtaining a more comparative understanding of the research topic. More importantly, the key advantage of using focus groups is the researchers’ face to face interaction with respondents and the opportunities to ask for clarification and follow-up questions to the responses given (p.3). That being said, focus groups contain the following limitations (p.5):

1. *Discussion content.* Irrelevant topics can be discussed since the discussion in a group interview is to a certain extent, controlled by the group itself. Also, there can be social desirability and reactivity among respondents,

2. *Dominant group members.* Discussions can be influenced by a couple of dominant respondents. There can be a significant influence on the views of the other respondents, which can skew the findings, and
3. *Quality of the discussions.* There is no control of group-makeup, which influences the quality of group discussions.

Hence, this researcher planned to minimize the limitations by taking a role as the moderator. Since this researcher was knowledgeable and specialized in Theraplay, the researcher functioned as an objective moderator who guided the discussion appropriately and facilitated effective discussions. For instance, the researcher attempted to invite opinions from respondents who tended to be listeners and often asked whether people agreed or disagreed with the opinions shared. Also having an experienced note-taker in the focus group helped the researcher fully focus on the group's interactions. All in all, the benefits of the data collection methods outweighed the limitations (Krueger & Casey, 2009).

Sampling

The respondents in the focus group were drawn from the same pool (N=19) of survey research. The researcher posted a sign-in sheet for two focus groups on the survey booth so voluntary participation was promoted. Ten people signed up for the focus group on July 18 and nine people signed up for the focus group on July 19. So, the total number of focus group respondents equaled nineteen. No monetary incentives were given to respondents but lunch was provided. The focus group respondents met the same criteria as the survey respondents. Ideally, the representations from different levels of Theraplay

training was desired, however it was not under the researcher's control in a voluntary participant exercise. Table 7 shows the detailed characteristics of the participants.

Table 7. Summary of Participants' Characteristics Data (N=19) for Gender, Country of Practice, Degree, and Level of Theraplay Training

	Group 1	Group 2	Total
Gender	Female 8 Male 2	Female 9 Male 0	Female 17 (89.5%) Male 2 (10.5%)
Country of practice	U.S 9 Other 1	U.S. 5 Other 4	U.S. 14 (73.5%) Other 5 (26. 3%)
Highest degree	Master's Degree 5 Ph.D or equivalent 5	Master's Degree 7 Ph.D or equivalent 2	Master's Degree 12 (63.2%) Ph.D or equivalent 7 (36.8%)
Level of Theraplay training	Level 1 or 2 Practitioner 5 Certified Thera/supervisor 5	Level1 or 2 Practitioner 4 Certified Thera/Supervisor 5	Level 1 or 2 Practitioner 9 (47.4%) Certified Thera/Super 10 (52.6%)

In this qualitative research study, the researcher served as the data collection instrument (Creswell, 2013) by being a moderator and facilitator of the discussion. The data was collected by group discussions with the questions from the focus group guide. The questions are listed below.

- How do you feel about Theraplay work for foster and adopted children and their families?
- How does Theraplay contribute to caregivers' understanding of their children's needs?
- What does Theraplay do for parenting skills in dealing with their children's issues?
Can you give an example?

- What does Theraplay do for children's behavioral or emotional symptoms?
- How do you use the sequence of Theraplay? How important is the sequence?
- How would you compare Theraplay intervention with other interventions?
- How do you increase a child's regulation through Theraplay?
- Are there other things you would like to say before we wind up?

Reliability in data coding can be checked in several ways. The most common is called member checking when research respondents review the data analysis and interpretation for accuracy (Creswell, 2013). Another common way is using an inter-rater reliability test with two coders that calculate the percentage agreement in coding to determine the accuracy of the coding process (Creswell, 2013). Inter-rater reliability with two coders⁵ was used in this study to enhance reliability and validity.

Data Collection and Analysis Procedures

The first focus group (N=10) was conducted on July 11, 2013 and the second focus group (N=9) was conducted on July 12, 2013. Each focus group consisted of respondents (N=10, N=9 respectively), one moderator (researcher), and one note-taker. The group discussions lasted fifty five minutes because it was conducted during the conference lunch time. The focus group respondents were assured of confidentiality through the informed consent process in the beginning. The discussions were audiotaped and were transcribed verbatim to text by the researcher⁶ (Hesse-Biber & Levy, 2011) and stored for future analysis. During the transcribing process, the researcher maintained

⁵ The peer reviewer who participated in case study analysis was the other coder.

⁶ It is because the process of transcriptions is part of the data analysis process.

trustworthiness and validity of the data-gathering techniques (Hesse-Biber & Levy, 2011).

Regarding data analysis, the researcher employed a qualitative content analysis. Content analysis can be used with either qualitative or quantitative data with the purpose of “providing knowledge, new insights, a presentation of case and a practical guide to action” (Krippendorff, 1980). Leech & Onwuegbuzie (2008) stated, “Content analysis focuses on how frequently codes are used to determine which concepts are most cited throughout the data.” It allows researchers to make inferences about social reality in a systematic way by recognizing patterns or themes (Hsieh & Shannon, 2005). In content analysis, counting the number of codes is preferred over grouping the codes together (Leech & Onwuegbuzie, 2008). Hsieh and Shannon (2005) defined qualitative content analysis as “a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or pattern” (p.1278). With its purpose of providing knowledge, new insights, a representation of facts, and a practical guide to action (Krippendorff, 1980), content analysis helped the researcher to attain a broad description of Theraplay practice and to draw the outcome of concepts describing the effectiveness in Theraplay in working with foster and adopted children and their families. Counting the frequency of use for each code was helpful to objectively describe the data. In content analysis, “the codes are usually deductively produced, yet they can be inductively produced as well” (Leech & Onwuegbuzie, 2008). One of the limitations of content analysis is that there is not any specific or “right way” of doing.

For content analysis, the researcher needed to classify and organize the data for the development of themes and later analysis. Themes or codes represent important meanings to the researcher (Braun & Clarke, 2006) and a set of various codes was organized in a “coding book.” (Mertens, 2008).

Two approaches to developing codes or themes are: inductive and deductive coding (Braun & Clarker, 2006). Inductive coding, or a bottom up approach, is a data-driven approach that allows the researcher to analyze the data without a preconceived coding scheme. Deductive coding is a theoretically-driven approach and begins with a theory or previous research results. In this study, the researcher attempted to use the interplay between deductive and inductive approaches. With the knowledge obtained from the survey research and from researchers preconceived knowledge of Theraplay, the researcher first developed important codes in code-book by closed coding (deductive approach) and later added emerging categories in code-book by open-coding (inductive approach). In this study, the researcher followed step-by-step description of data analysis strategies modified from suggestions by Elo & Kyngas (2007) and Hesse-Biber & Levy (2011):

Phase 1: Data preparation phase. The researcher first developed the code-book based on her prior knowledge and survey research results. Then, the researcher prepared the data for analysis by entering the focus group transcript in excel spreadsheet. Deductive analysis was first conducted by identifying a priori codes in transcript (closed coding).

Phases 2 and 3: Data exploration and induction phase. The researcher reviewed and reflected the data and organized open coding, explored emerging categories, and formulated an updated code book. These two phases were synergistic.

Phase 4: Reporting. The researcher assessed and interpreted the results what aspects of Theraplay practice had the most impact on foster and adopted children and families.

Ethical Considerations

Before starting the data-gathering process, the researcher obtained the approval of the Loyola University Chicago committee Institutional Review Board (IRB) for the appropriateness of the study. Regarding ethical concerns for gathering data from human subjects, the researcher ensured that there was no risk of damaging the dignity or welfare of the respondents. An informed consent was displayed at the beginning of the survey, which addressed the key ethical issues (see Appendix D): (a) general purpose of the study, (b) risks and benefits of participation, (c) participants' rights to withdraw their full participation or the option to not answer a question if they felt uncomfortable or do not wish to answer, and (d) contact information for the researcher. The researcher was available and accessible in case respondents wanted to contact her with questions or concerns about the study during data collection. Additionally, the research did not have any identifier information on the respondents; the researcher was the only person with access to their responses and the data was kept in a locked storage place.

In the data gathering process, the researcher took into consideration and bracketed her clinical biases and perceptions of this study. In order to conduct a bias-free research

study, the researcher endeavored to ensure credibility of this study and to increase objectivity. In addition, the researcher ensured that ethical practices were followed such as keeping confidentiality of the subjects, consent forms, survey data, and focus group data. Although the focus groups seemed to harm the anonymity of respondents, addressing group confidentiality helped the respondents feel at ease with discussing their opinions.

Furthermore, triangulation, peer reviews, and inter-rater reliability were employed to ensure its rigor and trustworthiness in analyzing qualitative data. Methodological triangulation occurred by conducting mixed methods of the qualitative study (case study and focus group) and the survey research. Investigator triangulation was also applied to case study by using the peer reviews in the data analysis process. The researcher compared her reflections with the peer researcher's reflections and incorporated a consensus in the findings to enhance the study's adequate rigor and trustworthiness to make inferences about the results.

CHAPTER FIVE

FINDINGS

This chapter reports the statistical findings for four research questions and additional findings in detail. Its main objectives are three-fold: (1) to report the findings of survey data analysis such as descriptive statistics, factor analysis, Pearson's correlations, and one-way analysis of variance (ANOVA); (2) to report the results of the case study analysis including the methodology, findings, and triangulation; and (3) to report the results of the focus group analysis such as the methodology and findings.

Survey Data Findings

Descriptive Statistics

This section analyzed personal characteristics and professional characteristics of the respondents. Information about the personal characteristics was shown in Table 3. The respondents' ages ranged from 20 to 70 over years old with a mean of 43 years old. The majority of the respondents (94.4%) were older than 30 years old. The respondents practiced in thirteen different countries, having outnumbered practitioners (68.9%) in the United States.

The information regarding professional characteristics was summarized in Table 4. Regarding professional affiliations, the number of counselors was highest (34.5%), and the number of social workers was second highest (24.1%). The majority of respondents held at least a master's degree (89.7%). The number of the respondents who were

certified Theraplay therapist or supervisors was second highest (33.3%). Regarding the years in clinical practice, further, approximately 53% had more than 8 years in clinical practice. Thus, the respondents in this study most likely had high levels of formal clinical training and experience (see Table 8).

Table 8. Level of Theraplay Training × Effectiveness of Theraplay Crosstabulation

Level of Theraplay training	Effectiveness of Theraplay						Total
	5.00	6.00	7.00	8.00	9.00	10.00	
(Group 1) Completed introductory or intermediate	100.0%	100.0%	66.7%	34.8%	56.5%	31.6%	48.1% (N=37)
(Group 2) Level 1 & Level 2 practitioner			16.7%	21.7%	21.7%	15.8%	18.2% (N=14)
(Group 3) Certified Therapist and Supervisor			16.7%	43.5%	21.7%	52.6%	33.8% (N=26)
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0% (N=77)

Note. % within Effectiveness of Theraplay

The descriptive statistics of the dependent variable (effectiveness of Theraplay) showed that the average rated score of the effectiveness of Theraplay was 8.48 out 10. Bar graphs in Figure 7 showed the visual distribution of sum of competency scales and effectiveness of Theraplay.

For the second part of the descriptive statistics, the researcher performed the crosstab analysis to see how the dependent variable (effectiveness of Theraplay) varied in relation to the independent variables (level of Theraplay training and practitioners' competency). First, the researcher looked for a difference between the level of Theraplay training and the practitioners' evaluations of the effectiveness of Theraplay. As shown in Figure 8, the respondents in group 1 (completed introductory or intermediate training) showed inconsistent responses to the effectiveness of Theraplay ranging from 5 to 10,

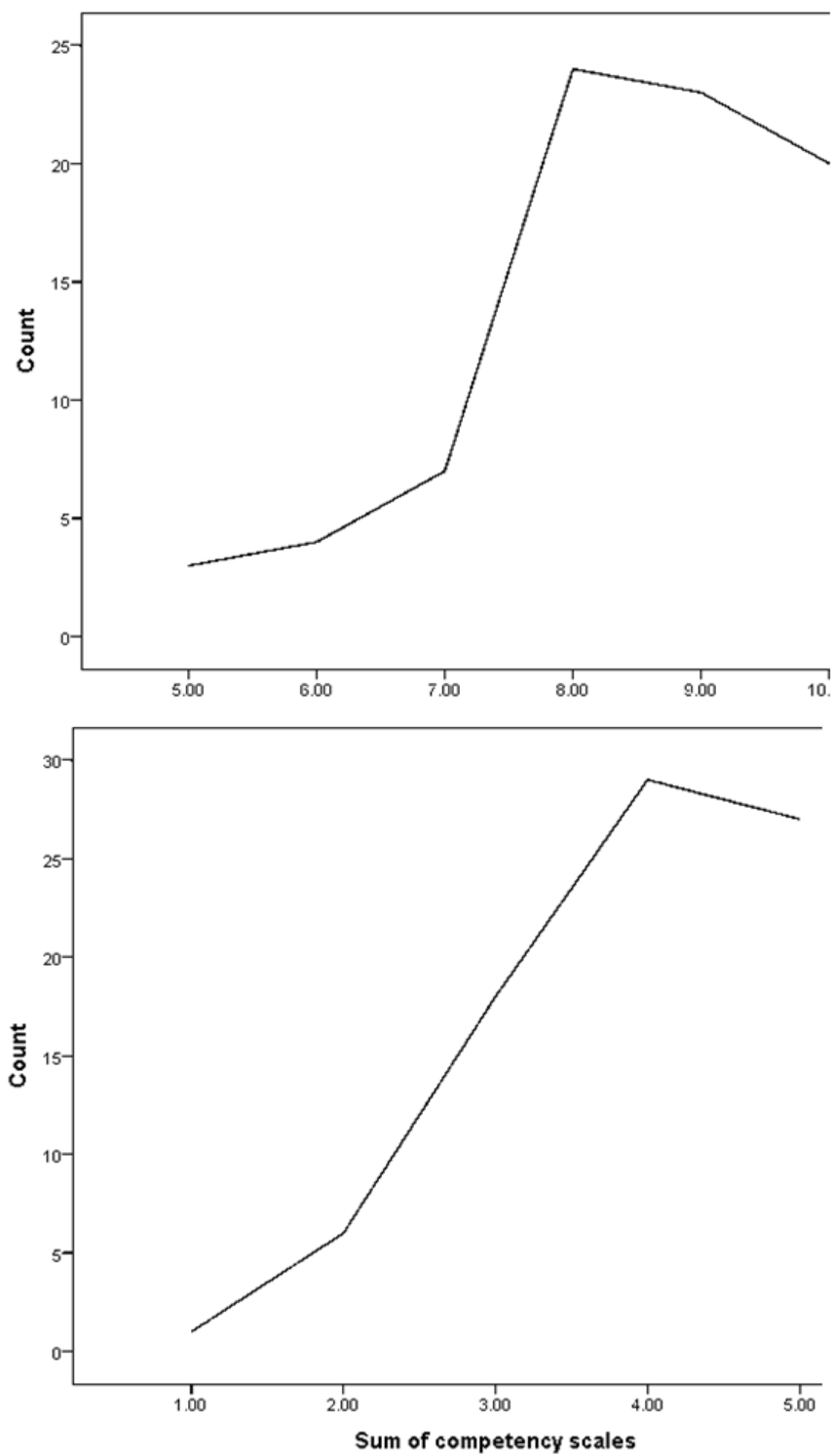


Figure 7. Bar Graphs: Sum of Competency Scales and Effectiveness of Theraplay

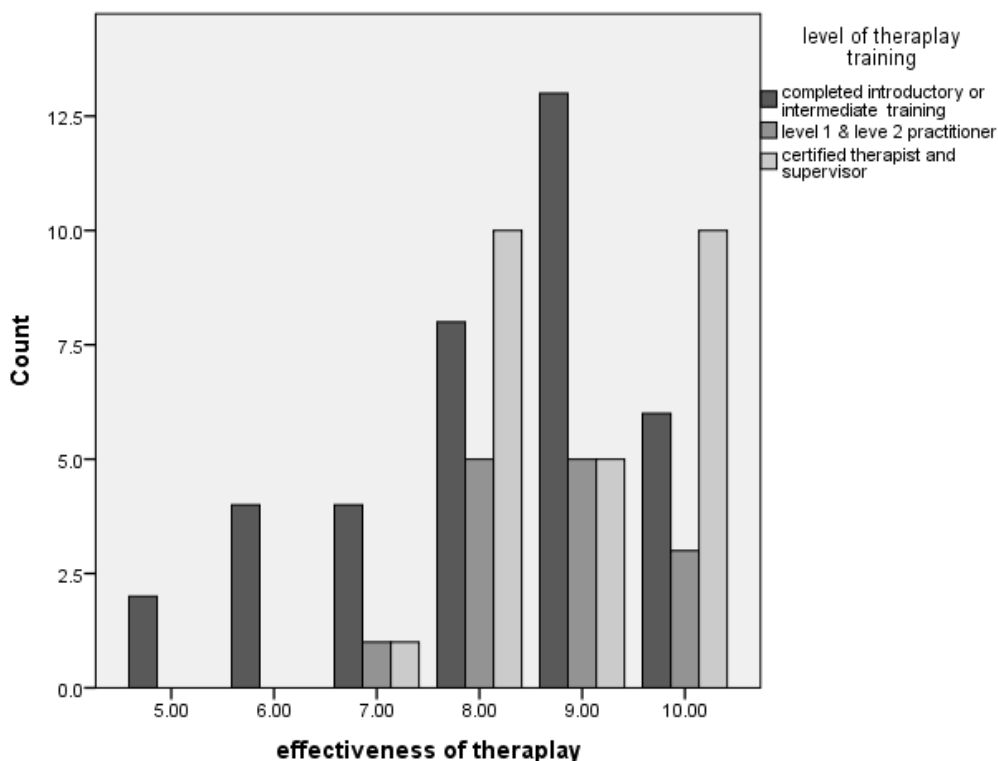


Figure 8. Crosstab Bar Chart Between Level of Theraplay Training and Effectiveness of Theraplay

while the other two groups with more training rated higher scores of effectiveness of Theraplay ranging from 7 to 10.

66.7% of the respondents who scored 7 were in group 1, while 16.7% of the respondents were in group 2 and 3, respectively. On the other hand, 52.6% of the respondents who scored 10 were in group 3, while 31.6% of the respondents were in group 1 and 15.8 % of the respondents in group 2.

Another crosstab was conducted between the practitioners' competency scale and the effectiveness of Theraplay. The practitioners' competency scale ranged from 1 to 5, where 1 means poor (group 1), 2 means moderately poor (group 2), 3 means average

(group 3), 4 means good (group 4), and 5 means excellent (group 5). As shown in graph 5.4, there were inconsistent responses from all groups regarding the effectiveness of Theraplay. For instance, the respondents in group 4 (the second competent group) scored the effectiveness of Theraplay ranging from 1 to 10, although it was outnumbered in score 8 and higher. Also, the respondents in group 1 (the least competent group) scored 9 for the effectiveness of Theraplay.

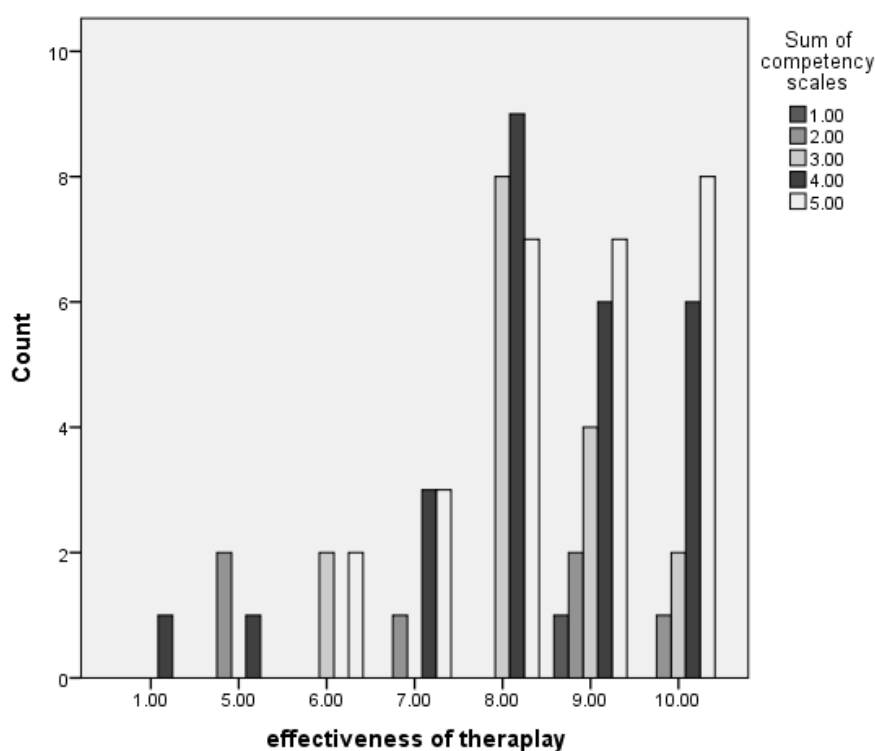


Figure 9. Crosstab Bar Chart Between Effectiveness of Theraplay and Level of Competency.

In conclusion, the descriptive statistics showed that the respondents who had more training reported higher scores on the effectiveness of Theraplay. The respondents who presented a higher level of competency tended to report higher scores on the

effectiveness of Theraplay but the responses were somewhat inconsistent in crosstab analysis. Further statistical analyses were performed to assure the results.

Table 9 shows the crosstabulation between effectiveness of Theraplay and level of competency.

Table 9. Effectiveness of Theraplay and Level Competency Crosstabulation

		Level of Competency					Total
		1.00	2.00	3.00	4.00	5.00	
Effectiveness of Theraplay	1.00				3.8%		1.3%
	5.00		33.3%		3.8%		3.9%
	6.00			12.5%		7.4%	5.3%
	7.00		16.7%		11.5%	11.1%	9.2%
	8.00			50.0%	34.6%	25.9%	31.6%
	9.00	100.0%	33.3%	25.0%	23.1%	25.9%	26.3%
	10.00		16.7%	12.5%	23.1%	29.6%	22.4%
Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Note. % within Level of Competency

Factor Analysis

An exploratory factor analysis was conducted to explore the interrelationships among a set of dependent variables (Pallant, 2011, p. 181). The suggested sample size for factor analysis is different among researchers, but generally the larger, the better (ideally 300 cases and a minimum of 150 cases) (p.183). Due to the small sample size (N=87), it was possible that the correlation coefficient among the variables were less reliable. Thus, the researcher only focused on exploring the pattern and correlations among dependent variables.

Two statistical measures by SPSS 22, Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and Bartlett's test of sphericity, resulted in good factor analysis (see Table 10). The KMO with .784 ($>.06$) suggested a significant value for a good factor

analysis.¹ Also, Bartlett's test showed significance ($p = .000$) for the appropriateness of factor analysis.²

Table 10. KMO and Bartlett's Test

Measure		Statistic
Kaiser-Meyer-Olkin Measure of Sampling Adequacy		.784
Bartlett's Test of Sphericity	Approx. Chi-Square	461.011
	df	55
	Sig.	.000

In the pattern matrix obtained from the factor analysis, the researcher identified four components in eleven dependent variables (see Rable 5-4). For the purpose of this study, the researcher needed to determine the most suitable dependent variable in performing a one way-ANOVA F-test. Among four components, the second component (good therapeutic outcome and effectiveness of Theraplay) directly answered the effectiveness of Theraplay.

The scree test³ also showed four components by plotting each of the eigenvalues of the factors. As shown in Figure 10, there were four points where the shape of the curve changed and one became horizontal.

¹ The KMO index ranges from 0 to 1, with .6 suggested as the minimum value for a good factor analysis (Tabachnick & Fidell, 2007).

² Bartlett's test of sphericity should be significant ($p < .05$) for the factor analysis to be considered appropriate (Tabachnick & Fidell, 2007).

³ Catell's scree test inspects the plot to find a point at which the shape of curve changes direction (Pallant, 2011, p. 184)

Table 11. Pattern Matrix

	Component			
	1	2	3	4
Parents increased appropriate parenting skills	.976			
Healthy parent-child relationship	.956			
Parents increased understanding of children's needs	.839			
Decrease child's behavioral (emotional) symptoms	.694			
Good therapeutic outcome		.924		
Effectiveness of Theraplay		.916		
Use of noticing			.918	
Considering optimal arousal			.811	
Use of Theraplay sequence				.966
Use of Theraplay principles				.725
Parents participation in viewing sessions			.452	.538

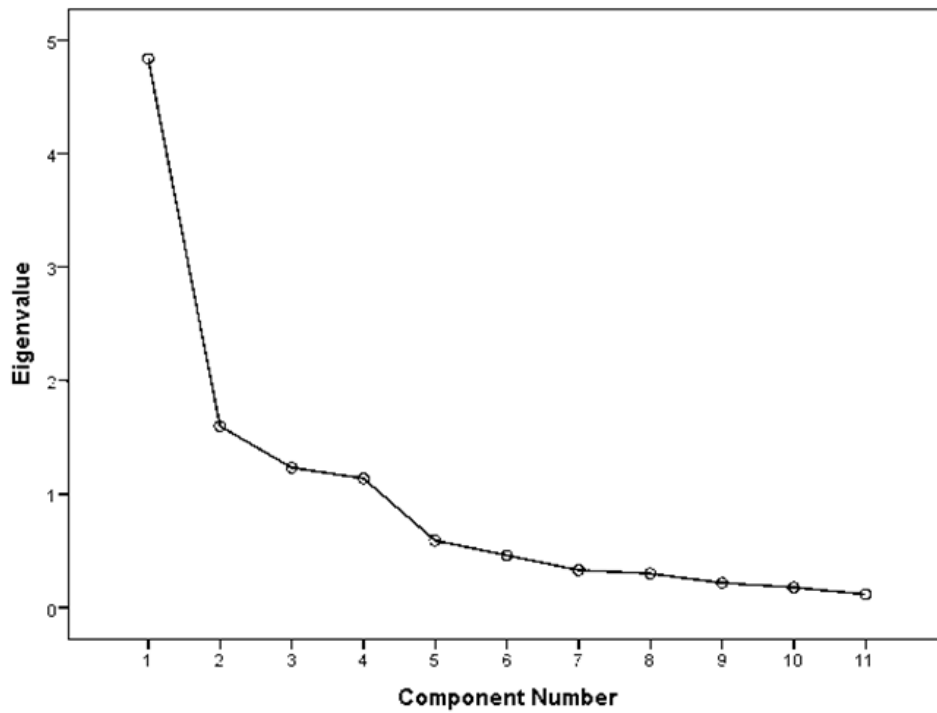


Figure 10. Scree Plot of Components in 11 Dependent Variables

Based on the results that these two variables (effectiveness of Theraplay and positive therapeutic outcome) in the same component were interchangeable, researcher determined to use “effectiveness of Theraplay” as the dependent variable in performing a one-way ANOVA F-test.

Correlation Analysis

Pearson and Spearman’s correlation analyses were performed to explore the relationship between a set of variables. Specifically, they were performed to answer the following two hypotheses:

H1. Practitioners’ Theraplay practice is associated with their evaluations of the use of Theraplay.

H2. The competency of practitioners is associated with their evaluation of Theraplay.

Following the descriptive statistics, correlation analyses were conducted.

A simple bivariate correlation (known as zero-order correlation) was conducted. First, the researcher performed a bivariate correlation (with 1-tailed significance test) between the effectiveness of Theraplay and practitioners’ level of Theraplay training, considering that a higher level of Theraplay training meant a higher level of Theraplay competency. The data in Table 12 suggests that there was a low statistically significant correlation between the effectiveness of Theraplay and the level of practitioners’ Theraplay training ($r_s=.22, p < .027$)⁴ (see Table 12).

⁴ The Spearman correlation coefficient is defined as the Pearson correlation coefficients between the ranked variables. r_s takes on values from .16 to 1, indicating for values of r_s , the correlation is too low to be meaningful.

Table 12. Correlation Between Level of Training and Effectiveness of Theraplay

			Effectiveness of Theraplay	Level of Theraplay training
Spearman's rho	Effectiveness of Theraplay	Correlation Coefficient	1.000	.220*
		Sig. (1-tailed)		.027
		N	82	77
	Level of Theraplay training	Correlation Coefficient	.220*	1.000
		Sig. (1-tailed)	.027	
		N	77	82

* Correlation is significant at the 0.05 level (1-tailed).

Next, the researcher performed the correlation between the years in Theraplay practice and the effectiveness of Theraplay and gained the results that there was a strong, statistically significant correlation between the years in Theraplay practice and the effectiveness of Theraplay (Pearson's $r = .301$, $p < .005$)⁵ (see table 5-6).

Table 13. Correlation Between Years in Theraplay Practice and Effectiveness of Theraplay

		Effectiveness of Theraplay	number of years in Theraplay practice
Effectiveness of Theraplay	Pearson Correlation	1	-.301**
	Sig. (1-tailed)		.005
	N	81	74
Number of years in Theraplay practice	Pearson Correlation	-.301**	1
	Sig. (1-tailed)	.005	
	N	74	79

** Correlation is significant at the 0.01 level (1-tailed).

⁵ Pearson correlation coefficient r takes on values from -1 to +1. The size of the absolute value provides an indication of the strength of the relationship.

Lastly, the result of Pearson's correlation between the effectiveness of therapy and result of the competency assessment suggested a small statistically significant correlation (Pearson's $r=.19$, $p < .049$) (see Table 14).

Table 14. Correlation Between Competency and Effectiveness of Theraplay

		Effectiveness of Theraplay	Sum of competency scales
Effectiveness of Theraplay	Pearson Correlation	1	.192*
	Sig. (1-tailed)		.049
	N	80	75
Sum of competency scales	Pearson Correlation	.192*	1
	Sig. (1-tailed)	.049	
	N	75	81

* Correlation is significant at the 0.05 level (1-tailed).

Similar to the results of the descriptive statistics, the findings from Pearson's correlation analysis suggested some statistically significant relationships between the dependent variable (effectiveness of Theraplay) and three independent variables (level of Theraplay, years of Theraplay practice, sum of competency scales), respectively. Therefore, the following conclusions were obtained from Pearson's correlation: first, there was a positive association between practitioners' Theraplay practice and their evaluation of Theraplay. Also, there was a positive association between practitioners' competency and their evaluation of Theraplay.

One-Way Analysis of Variance

A one-way between-groups ANOVA was conducted to determine whether there were significant differences in the mean scores of the dependent variable across three groups (introductory/intermediate trained, levels 1 & 2, and the certified group). Post hoc

tests of multiple comparisons were also carried out to explore exactly where these differences existed.

To use the one-way ANOVA, it was necessary to examine whether the data met the three assumptions underlying the F-tests:

1. The observations were independent. This assumption was met since the questionnaires were administered individually and randomly. Without meeting this assumption, ANOVA could not further perform.
2. The normality of the dependent variable was examined by performing the Kolmogorov-Smirnov test and the Shapiro-Wilks test for normality. Although the outlier (#25) was removed, the results did not confirm that the dependent variable met the normality assumption (see Table 15).

Table 15. Tests of Normality

	Kolmogorov-Smirnova			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Effectiveness of Theraplay	.186	81	.000	.881	81	.000

^a Lilliefors Significance Correction

This result was predicted from descriptive statistics of effectiveness of Theraplay, which showed it skewed to the right side, instead of a bell shape. Further, it is often difficult to see the normality of the sample in a small sample size.

3. The homogeneity of variance was examined by Levene's test for homogeneity. The results showed insignificant (.079), meaning that they met the equal variance assumption (see Table 16).

Table 16. Test of Homogeneity of Variances

Levene Statistic	<i>df1</i>	<i>df2</i>	Sig.
2.629	2	74	.079

The result of the ANOVA F-test of the dependent variable (effectiveness of Theraplay) showed that there was some statistically significant difference in the level of Theraplay training ($F=3.00$, $p=.05$) (see Table 17).

Table 17. ANOVA Effectiveness of Theraplay and Level of Theraplay Training

	Sum of squares	<i>df</i>	<i>M</i> square	<i>F</i>	Sig.
Between groups	8.790	2	4.395	3.001	.056
Within groups	108.379	74	1.465		
Total	117.169	76			

Because the F-value was statistically significant, a post hoc procedure was needed to follow. The researcher performed post-hoc tests to explore which group was different from which other group. The statistical significance of multiple comparisons, which meant the differences between each pair of groups, was provided in Table 18 multiple comparisons. As shown in Table 18, there was a statistically significant difference between the group of respondents who completed introductory/intermediate training and the group of respondents who were certified therapists and supervisors ($p < .020$). Thus, the post hoc analysis confirmed that there is a significant association between practitioners' level of training and the effectiveness of Theraplay.

Finally, the mean plots indicated some positive linear relationship between the level of training and the effectiveness of Theraplay (see Figure 11). The graph highlighted the difference between the group with introductory training and the group

with intermediate training. The mean of certified Theraplay therapist/supervisors showed higher level of evaluation of the effectiveness of Theraplay ($M = 8.9$, $SD = .97$) than the respondents who reported completing introductory and intermediate training ($M = 8.1$, $SD = 1.4$).

Table 18. Post Hoc Test Multiple Comparisons

(I) Level of training (J) level of training	<i>M</i> dif. (I-J)	<i>SE</i>	Sig.	95% CI	
				Lower bound	upper bound
Intro or intermediate level 1 or 2 certified or supervisor	-.52410	.37973	.171	-1.2817	.2315
	-.73389*	.30970	.020	-1.3510	-.1168
Level 1 or 2 intro or intermediate certified or supervisor	.52510	.37973	.171	-.2315	1.2817
	-.20879	.40118	.604	-1.0082	.5906
Certified or supervisor intro or intermediate level 1 or 2	.73389*	.30970	.020	.1168	1.3510
	.20879	.40118	.604	-.5906	1.0082

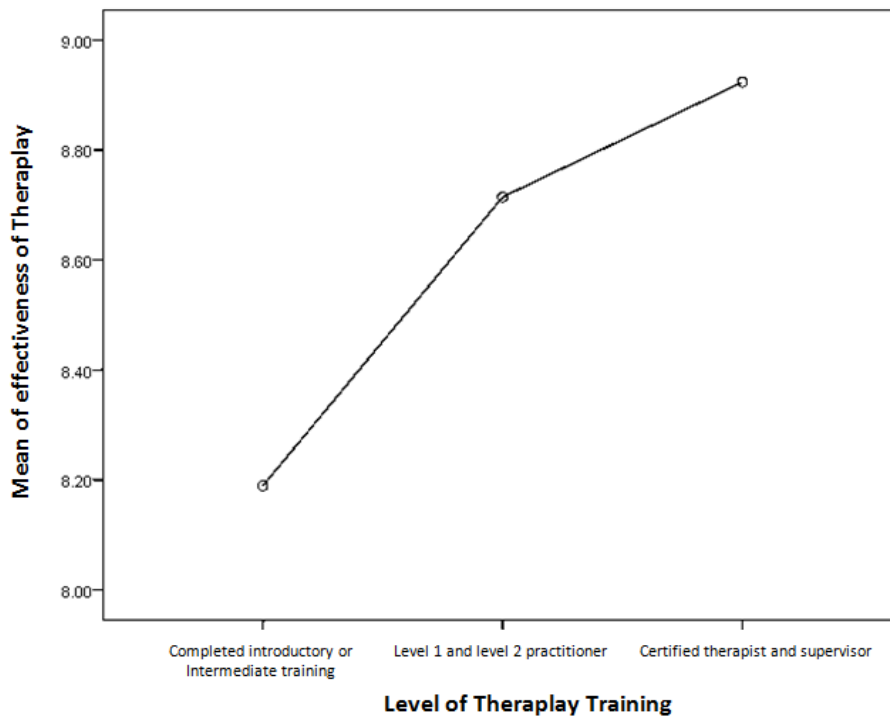


Figure 11. Mean Plots

The one-way ANOVA analysis results showed that there was some statistically significant differences between the effectiveness of Theraplay across the three groups. The overall findings from the descriptive statistics, Pearson correlation, ANOVA, and post - hoc tests showed that there was an association between Theraplay practice (level of Theraplay training) and the evaluation of Theraplay (effectiveness of Theraplay).

Case Study Analysis

Qualitative content analysis was used to investigate the single case description. The data was a one-page case description by a practitioner from the quantitative study. The goals of the analysis were twofold: 1) to understand the practitioner's evaluation of the use of Theraplay in treating an adopted child and his family, and 2) to infer the practitioner's competency in Theraplay treatment. The approach was to analyze the transcript for Theraplay concepts and application. The following research questions were further explored through this analysis:

1. How do practitioners evaluate the use of Theraplay in treating the needs of foster and adopted children and their families?
2. How do practitioners describe that use of Theraplay in treating the needs of foster and adopted children and their families?
3. How effective is the use of Theraplay help foster and adopted children and their families?

Triangulation

In order to check and establish the validity of the study and to deepen the researcher's understanding of the study, the researcher utilized triangulation by analyzing

research questions from multiple perspectives (Patton, 2002). In particular, methodological triangulation was used for this study by conducting mixed methods of two qualitative studies (case study and focus group) and a survey study. The research questions were investigated to see whether the conclusions from each of the methods were the same. In addition, investigator triangulation was also applied to the case study by using the peer researcher in the analysis process. In order to triangulate the data, the researcher compared her reflections with the peer researcher's reflections and incorporated a consensus in the findings.

Methodology

One of the challenges of content analysis is that "it is very flexible and there is no simple right way of doing it" (Elo & Kyngas, 2007). The researcher also faced the challenge of having insufficient data to attain a broad description. Therefore, the researcher approached the inductive data analysis process with more of an emphasis on inferences and reflections than typical content analysis would. As a certified Theraplay therapist and supervisor, the researcher's perspective was a key component of this analysis. The researcher's reflections were included as a separate source of data. The researcher reviewed and analyzed the data from a value free perspective by reading and coding the case description using a procedure called open coding (Patton, 2002). The researcher went line-by-line, identifying significant statements (Corbin & Strauss, 2008), which were the words, phrases, or sentences that were listed in coding the categories and then integrated her clinical knowledge of Theraplay to understand the case description

through her practitioner's lens. The researcher's Theraplay practice knowledge was applied to understand the meaning of the practitioners' evaluations.

Findings

The case was divided into four main categories: (1) Client's Characteristics, (2) Practitioner's Diagnosis, (3) Theraplay Sequence, and (4) Measurement. The researcher first reflected on each main category separately and then formulated the overall meaning and findings.

Client's characteristics. The client in the case study was an adopted seven -year-old Caucasian boy. The child was first placed with his extended biological family at six weeks old, and then adopted by his current family at the age of two. There were incidents of child abuse before his adoption. For instance, the child had a broken arm when he was three weeks old. This information proved that his parental care was unstable and inconsistent until he was adopted. Researcher's Reflection: Through the lens of attachment theory, the researcher hypothesized that this child might fail to build a secure base at an early age, which could be the fundamental scaffolding for a healthy internal working model, and his ability to view himself as worthy and to view the primary caregiver and the world as safe and positive might be disrupted. Thus, this case could be a typical example of an adopted child with multi-faceted clinical issues (Baden, 2007; Bimmel, et al, 2003; Hoksbergen & Laak, 2007, etc).

Practitioner's diagnosis of the child. There were five sub-categories listed in Table 19.

Table 19. Diagnosis of the Child

Generic category	Subcategory (descriptions of concern)
Medical concerns	Multiple heart defects, seizure disorder, asthma, allergies
Cognitive concerns	314.01 ADHD w/hyperactivity
Neurological concerns	299.80 PDD; sensory processing disorder
Mental health concerns	309.81 PTSD (very early child abuse); 313.89 RAd (severe); 296.54 Bipolar I
Behavioral concerns	Suicidal attempts, homicidal attempts, sexual abuse of other children, abuse of animals, destruction of property, hallucination, and severe affect dysregulation

Researcher's reflection: The practitioner described the five areas of concerns for the child. Based on the summarized descriptions on Table 19, the researcher assumed that the challenges in implementing treatment for this child could be insurmountable. This child presented not only mental and behavioral concerns, but also medical and neurological concerns. At the same time, the researcher also understood that Attention Deficit Disorder (ADD) with hyperactivity, Pervasive Developmental Disorder (PDD), and Reactive Attachment Disorder (RAD) were often diagnosed together among children. Since DSM-V diagnoses were made based on behavioral observations, distinctive descriptions among these diagnoses were not possible. There were common overlapping, gray areas for the causes or triggers of a certain behavior. For instance, hyperactivity can be caused by ADD, sensory processing issues in PDD, or trauma reaction from RAD. Therefore, the researcher understood the meaning of the multiple diagnoses of the client as the practitioner's attempt to express her initial profound difficulty in facing this case. It was also important to note that the practitioner utilized a holistic, multi-system approach

in treating this child. She incorporated psychopharmacological medication management by placing the child in a school that provided the attachment approach along with a high level of structure and she also provided family care programming. Thus, the successful result of this case should not be solely attributed to Theraplay treatment. It should also be attributed to the other support systems and interventions utilized in this treatment.

Theraplay sequence. Table 20 shows the categories obtained from the Theraplay sequence.

Table 20. Categories Obtained From Theraplay Sequence

Generic categories	Subcategories
Length of treatment	About 1 year
Typical session	Began with a focus on structure, a sense of safety, the acceptance of nurture, the acceptance of engagement, and then ability to master challenge
Initial sessions	Focused on creating a sense of safety and acceptance of the child
Next sessions-aimed optimal arousal	Co-regulation, use of rhythm and attunement, positive stimulation of physical senses
Create new meaning	Shared experiences of others
Next level of sessions	Accept challenge and mastery, self esteem
Final Sessions - new internal working model	Positive and productive interactions with others (including families)

Researcher's Reflection: Table 20 summarized the core categories derived from the data. The researcher was immersed to understand the data's meaning, intention, consequence, and content (Downe-Wamboldt, 1992). Theraplay's four dimensions

(structure, engagement, nurture, and challenge) were taken into consideration in a typical session. More importantly, the practitioner emphasized the word “safety” in her initial session. The concept of safety is regarded as essential in treating traumatized children. According to Perry (2001), children cannot connect to others if they are not safe. The emphasis on safety in the beginning of Theraplay treatment indicated the practitioner’s competency of trauma work and knowledge of the traumatized brain in Theraplay. After building the relationship and safe environment in treatment, the practitioner stressed the importance of the “nurture” dimension using co-regulation, use of rhythm, attunement, and positive touch. It seemed appropriate to incorporate regulation and nurture after the safety component was created. Then, the practitioner moved onto the phase of “meaning making” to process the child’s early trauma. “Meaning making” is an important concept in trauma work because a traumatized child begins his journey of healing by making sense of his traumatic experience (Hughes, 2011; Perry, 2001). Therefore, the researcher interpreted that the practitioner was trained in other trauma therapies along with Theraplay. Based on the fact that the practitioner included the “challenge” dimension which helped the child increase his self-esteem and coping strategies, the researcher reflected that the practitioner presented a high level of competency in Theraplay and rigorously applied Theraplay while treating this child. The practitioner’s step-by-step systematic Theraplay sequence with an emphasis on different dimensions in different phases of treatment perhaps led to the success of this case.

Theraplay sequence. Table 21 shows the categories obtained from the measurements.

Table 21. Categories Derived From Measurements

Generic categories	Subcategories
Family Involvement	Adoptive mother, older step-sister (highly) Adoptive father, extended family members (minimally)
Other party involved	Respite care providers
Overall symptom alleviation	No hallucinations, no sexualized behavior for 8 months, no suicide ideation verbalization or attempts for 6 months, no physical aggression to others or property for 3 months, decreased affect dysregulation down to 2-3 times per month. Elimination of aggression toward step-sister (developed engagement with step-sister in playful activities).
Practitioner's reflection 1	"I did not expect this level of success due to the extensive level of developmental, medical, neurological deficits experienced by this child."
Practitioner's reflection 2	"It is a testament to the persistence and dedication of the family members, especially the mother, who were able to provide a high level of attunement to the child, and de-personalize the child's action from their relationship with the child."

Researcher's Reflection: The practitioner measured the success of the case in multi-levels. She first explained the family involvement. The adopted family was highly involved in the sessions and other family members were minimally and gradually involved. The family involvement fulfilled Theraplay philosophy as a relationship-based model. In addition, respite care providers were involved to learn about Theraplay and used this approach in consistently providing the attachment-based model in order to meet the needs of the child. Secondly, the practitioner reported overall symptom alleviation as

a measurable outcome of treatment (see Table 22). The practitioner proved the effectiveness of Theraplay in decreasing behavioral and emotional issues. Furthermore, the practitioner's reflections supported the positive outcome. In the practitioner's testimonial, two of the key words she used were "persistent" and "dedication" regarding the family members, especially the adopted mother. The researcher's intuited those two key words as "persistent beliefs in utilizing the Theraplay approach among family members" or "practitioner's consistent use of the Theraplay approach." By providing consistent attachment-based care, the practitioner and the adopted mother were able to build a healthy relationship between the parent and the child which became a crucial healing factor in alleviating the child's clinical issues. The practitioner deemed Theraplay as an effective treatment in decreasing behavioral and emotional issues of an adopted child by helping him build a strong relationship with caregivers, building his self-regulation, and helping parents gain a better understanding of their child.

Focus Group

Content analysis refers to a systematic research method that is used for making replicable and valid inferences from data to the research context (Krippendorff, 1980). It was used to examine the transcripts obtained from two focus groups. The goals for the analysis were threefold: 1) to explore the in-depth meaning of numeric results from survey questions about Theraplay practice, 2) to understand the practitioners' evaluations of the effectiveness of Theraplay in helping foster and adopted parents, and 3) to understand the practitioners' evaluations of the effectiveness of Theraplay in helping

foster and adopted children. The following research questions (earlier examined using the case study) were explored through this analysis:

1. How do practitioners evaluate the use of Theraplay in treating the needs of foster and adopted children and their families?
2. How do practitioners describe that use of Theraplay in treating the needs of foster and adopted children and their families?
3. How effective is the use of Theraplay help foster and adopted children and their families?

Methodology

Focus group analyses were done using four distinctive methods to ensure the reliability and rigorous exploration: Inter-rater reliability, closed coding, open coding, and numeration.

Inter-rater reliability test. The transcripts of the first two focus group questions (how do you feel about Theraplay work for foster and adopted children and their families and what does Theraplay do to contribute to caregivers' understanding of their children's needs?) were selected for the inter-rater reliability test. The researcher and the coder independently conducted closed coding for the data of the first two questions in focus group one, which were entered into the spreadsheet by the researcher based on the initial code-book. The results of the closed coding were compared for the inter-rater reliability test (see Appendix F). The rates of each code were scored based on the following criteria: if both coders came up with the exact same codes, it yielded 100%; if both coders had the same main code, but one coder added one more code, it yielded 75%; if both coders had

two codes, but one was the same, it yielded 50%; if there were different codes, it yielded 0%. The results of the inter-rater reliability test yielded 89.07% agreement (see Table 22). The resulting percentage agreement was high enough to insure the inter-rater reliability. Therefore, the researcher proceeded by open coding independently.

Table 22. Inter-Rater Reliability Test for Focus Group

Data	% agreement
Description of Theraplay	87.50
Theraplay's contribution to caregivers' understanding	90.63
Sum of percentage agreement	89.07

Closed coding. There was an interplay between the use of inductive and deductive reasoning for this focus group analysis. The data analysis process first began by formulating an initial code-book based on the documents of Theraplay and the researcher's experience of Theraplay. A total of twenty-one apriori codes were first deductively produced and then refined after being reviewed by the other coder. The initial code book derived from apriori codes (which were created before the data analysis) was only used to check for inter-rater reliability. After finishing the inter-rater reliability test, the researcher explored emergent themes with inductive open coding and reorganized the code-book into seventeen identified themes. Finally, the researcher explored the code frequency using a deductive approach with the finalized code-book.

Open coding. The researcher put aside the deductively developed code-book and began inductive open coding to explore the emerging themes from the data. The researcher was cognizant of her clinical knowledge and made a conscious effort to document those before beginning the analysis in order to solely focus on the themes

emerging from the data. The researcher immersed herself in the data in keeping with the process of qualitative research (Patton, 2002). While reading the discussions several times, the researcher made notes and explored patterns in the data to identify emerging codes.

Numeration. The next step involved deciding the unit of coding. The researcher decided on a meaningful unit to use by considering the research questions. In qualitative content analysis, themes or categories are usually used as a meaningful unit for analysis (Patton, 2002). For this study, the unit of coding was based on a theme and the size of meaningful units ranged from a sentence to a paragraph. If a sentence contained more than one theme of interest, the sentence was encoded into two separate thematic codes. Each statement was coded based on its context as well. For instance, one practitioner commented, “I’ve used it with older children, but use caution if using in foster care because it is unknown if they will return to their family and I don’t want to start attachment work and have it disrupted.” This comment had two themes: “start attachment work” referred to the theme of describing Theraplay as attachment work, and the context of the sentence referred to the theme of the challenges of conducting Theraplay. In other words, sentences that contained one or more themes were encoded in one or more codes accordingly. Then, the researcher counted the frequency of each subtheme. After completing numeration, the researcher reorganized the code-book with recurrent themes in the data (see Appendix G).

Findings

Coding: Themes. The researcher analyzed the data based on questions. The overall summary of the major themes in each question were as follows.

Overall description of the use of Theraplay. The practitioners commented that attachment work in Theraplay meant building an internal working model, which was addressed as a goal in Theraplay. It was ideal if children had their parents as an attachment figure, but sometimes temporary foster parents and even practitioners were considered attachment caregivers who helped the children develop a positive internal working model.

R9-1⁶“Creating an alternative working model is often done with goals and actions for children. There caregivers were not there when the children first developed their internal working model. I work with birth parents that blocked some of their parenting aspects. I am helping children make an alternative working model with their parents, even though they end up being placed at foster care. When they have a chance to build an alternative working model, their transition to a new place (foster care) is much easier and smoother. Although they experience the loss of their parents, they are reacting like “Ok, I won’t be with my parents, but I have a great connect with my parents and they will always love me.” The shift in their views (from alternative working model) helps them reduce their behavioral problems and make them do better in a new foster home. These children always remember their Theraplay experience and I think I was the attachment figure in their alternative model.”

Other goals discussed in Theraplay were regulation and positive experience.

There were divergent views on the appropriate ages for the use of Theraplay. Some stated that Theraplay was a treatment choice for children age 6 and under, while others believed that Theraplay could be effective at any age.

⁶ R9-1 means respondent 9 in focus group 1

R2-1 “The new relationship created from Theraplay protects children when they are placed in foster care homes. I know some of you use Theraplay for young children but I often use it with adolescents that are frozen in their younger emotional stage. The kids need to be seen and felt and heard.”

Theraplay practitioners were trained to conduct observational testing called the Marshack Interaction Method (MIM) before implementing Theraplay. Conducting the MIM often delayed Theraplay work because it required three and four visits to complete. Also, the United States foster care system creates some challenges in working with foster children because children are often placed in multiple foster homes until they are settled.

The power component in Theraplay was described as experiential and enjoyable. By focusing on being in the moment (here and now experience) with Theraplay activities, the family felt safe and connected with one another to resolve the family issues.

R1-2: “I really enjoy Theraplay. In terms of how I feel about adopted and foster families, I think it is a very ideal sort of treatment technique because it is experiential and generally enjoyable for families. I found it very effective.”

In terms of the effectiveness in meeting the needs of foster and adopted children and families, eight participants reported that Theraplay was an effective and ideal tool.

R8-2: “I feel strongly about Theraplay as an important intervention for foster and adopted children. For those who do not have a positive internal working model, I wonder what they can do without Theraplay. I still remember the image of the child after I did the first Theraplay session about 4 years ago. I can’t recall what I did exactly with the child. I think it might not have been that great since I was a novice at practicing Theraplay, but I remember that his face kept lingering in my mind even after the session. I am the kind of person who normally put the work behind me, but the impact of the Theraplay session was so strong. The child came to me so strongly and I felt very connected with the child after the first session. That experience made me wonder that if I felt like that about that child, how well could it work with his parents? My beliefs were accurate and I see many mini-miracles in Theraplay work for foster and adopted children. I feel so sure that Theraplay helps kids and parents rebuild their internal working model.”

Theraplay could be used alone or integrated with other interventions. The theme of a “positive internal working model” was addressed. The Maschack Interaction Method (MIM), which is an observational assessment to explore the dyad between parent and child, was stressed as an important tool to help parents increase parenting skills. Lastly, the impact of Theraplay on practitioners was also shared.

Theraplay’s contribution to caregivers’ understanding of their children’s needs.

A practitioner commented on the importance of helping parents depersonalize their experience with children.

R5-1 “When the child is rejecting something, they are not rejecting the parenting. They are rejecting what they are receiving. I think vulnerability. Theraplay helps parents understand the underlying meaning of their child’s behavior.”

The experiential component of Theraplay was stressed to help parents understand the nuances of their children’s behavior. Theraplay was described as a therapy that provides a larger framework for interpreting children’s behavior and helping parents discover insights into their own history and anxiety that negatively influence their children’s behavior.

R1-1: “Definitely, I agree it’s experiential. I can see that we would get hung up on the language part. Instead, it is watching how you are feeling. When that experience clicks to the parents, the impact is humongous. Parents begin their journey to see the world through the eyes of their child, which helps them understand and acknowledge what their child is going through.”

The MIM and the practice of reviewing videotaped sessions were crucial tools in increasing caregivers’ understanding of their children’s needs.

The practitioners used the four dimensions of Theraplay to increase the caregivers’ understanding of their children’s needs. In particular, the “nurture” dimension

was stressed to help parents understand why foster and adopted children have difficulty receiving care from their parents.

R1-2: “I think the other piece of psycho-education that is important is the four dimensions. When I provide the information about what the four dimension are, why they are, and what behaviors are fit with each dimension, as well as what needs are for each dimension, that helps parents organize their child’s behavior and better understand the child’s behavior in the whole context of the child’s history. This helps parents to not take their child’s behavior personally. You know, I have one parent who said when I explained nurture, “Oh, that’s why she won’t let me wash her in the bathtub. That’s why she can’t let me do that. She doesn’t feel safe. It’s not that she doesn’t want to take a bath and that she is being defiant.” It helps them to be able to view it through a different level.”

Practitioners commented that Theraplay helped parents understand the underlying meaning of their children’s behavior. The MIM or videotaped session review was again stressed as an important tool to increase parents’ understanding of their children’s needs. It also helped parents gain an understanding of their strengths and weaknesses as parents.

R4-2: “Linking with that, I think the MIM assessment is very powerful to allow the parents look at that from this attachment angle. Parent can grasp the four dimensions in understanding their children’s behavior and exploring their parenting skills. Once they are aware of their strengths and weakness within in dimensions, it is much easier for them to understand the interactions with their children. Some can easily see their contribution to the child’s negative behavior.”

When working with parents, practitioners have the challenge of working with difficult parents as well. Difficult parents are considered parents who have negative views of their child, are not ready to grasp Theraplay concepts, and have their own issues. One of the suggestions for handling difficult parents was to have them watch the video reviews for educational purposes and to show them experiencing shared joy with their child during the session.

Parenting skills in Theraplay. The experiential component of Theraplay helped the parents increase their own self-awareness and helped them interpret their children's behavior differently (mostly positively). By observing and participating in Theraplay sessions, parents gradually integrated a different approach to their child and learned a new sequence of interaction skills such as "repair and reunion."

R8-1: "I think parents learn a new sequence of interactions. They learn to lead physically instead of just parenting verbally. They learn different words and they tend to be positive words."

Also, the modeling of practitioners who consistently paid attention to the child's positive aspects during sessions was considered an important factor in shifting parents' negative views of their child. Theraplay helped parents gain a more fundamental base of change in parenting.

R10-1: "When you first asked that question, I thought of one of my very first Theraplay session, a case twenty years ago that was a mother who had adopted three children. The youngest one was clinging to the mother and wouldn't get close to me and when I was turning onto the camera, he had Miami spits on me. You know. He is like three or four years old and our first three sessions was him just screaming and screaming and, screaming. When he took a breath and was not screaming, I just putting the shoes on side and "Oh, good, there is the nice stopping place." And after about the third or the fourth session, at the end, something was shifting for the child. The mother was observing and she cried behind the mirror. Something shifted for this little boy and he had fun that time. And he turned and looked at me and said, thank you, thank you, thank you," just over and over and over again. So I continued to work with him, his mother, and his brother. The mother wrote a letter that listed things that she had learned. She wrote, "I can know my son. I can get cues from him, which I can use to help him get prepared for getting into the car and doing things. I don't have to interfere so much during the interactions with his brother." I mean she had 6 or 7 things she expressively and clearly learned."

Three successful case examples of Theraplay's impact on parenting skills were illustrated. The first case example showed the use of playful Theraplay activities to redirect a child's oppositional behavior.

R2-2: "I have a parent with a 3 year old. He used to throw a fit getting on a train. His mother started carrying cotton balls in her pocket because she learned that he needed to be able to move, but being on the train, he couldn't do that. So, he would have a fit before he got on because he knew that he would need to be still, quiet, and peaceful. So, she would bring cotton balls and she would give them to him right when the train came in. And while they were waiting, they were throwing cotton balls. She would throw them back to him and sometime she would have stack the newspapers and have him punch the newspaper. So she really learned and took it to the streets, literally, for the child to let him practice healthy coping."

The other case example described the use of Theraplay activities for regulating a child. The last case example showed successful use of the four dimensions to help parents gain parenting skills. Teaching Theraplay core concepts to parents was addressed to help parents increase parenting skills. Among Theraplay core concepts, teaching parents about attunement to the needs of their child through modeling was stressed as the best parenting skill. "Parents' increased sensitivity toward reading their children's signs for their unmet younger needs" was also identified as a parenting skill gained through Theraplay.

R7: "Overall, the parents' sensitivity is increased; they see the different way of doing things with children. For example, I had a case with one child who couldn't sleep at night and the parents started to sing and make her roll and they could see after just five minutes that it corrected their child. They couldn't see it before, so I think they gained increased sensitivity to read child's signs from her younger level."

Children's behavioral or emotional symptoms in Theraplay. Theraplay was described to help children calm down, be cooperative, be regulated, and have fun. In an outpatient setting, all agreed that Theraplay was effective in decreasing emotional issues

such as anxiety, depression, and low self-esteem. By reducing anxiety through Theraplay, children felt safe and learned social skills by role playing.

R10-1: "I think Theraplay is very helpful in the cases that need help building the relationship and it is also helpful with kids who have anxiety or are afraid to try things and can't really have fun. They don't know that they can have fun. They don't feel competent, so if they can help their self-esteem, they can help themselves. "Maybe I can do that. I can try it." It helps those more depressed and anxious kids understand that it is worth being part of the world."

It was also described as being effective in building a good connection in conjunction with cognitive behavioral therapy. Theraplay helped the children with autism and children with other special needs decrease behavioral tantrums and physical aggression because the practitioner modeled and demonstrated how to feel safe in a session by "cognitively labeling replacement behaviors." Modeling worked well, although it took a while for the successful outcome to happen. Further, creating a trusting environment helped the child feel safe. Theraplay helped children increase the repertoire of play skills and interpersonal plays.

R3-1: "With the more complicated children I think there is an issue of generalization. When the children establish a trusting environment, they learn to predict how you are going to be with them, here and now. Then I think you have to specifically program that and included that in your other circles involved with the child. I would imagine the foster and adopted children would need it, too. It is very environmentally specific about where the child is going to feel safe. You know, people have to prove to me that this is the safe place."

Challenges to the positive changes in the children's emotional and behavioral issues included medical conditions such as fetal alcohol syndrome and intellectual delays.

For children with behavioral issues, the practitioners experienced big power struggles in the beginning, but their goals were usually to have the child stay and be presenting in the session without giving up and doing repeated set-limits for aggressive

behavior. A therapeutic alliance was built in the midst of witnessing children's struggles during sessions. Structure along with good attunement helped children decrease their behavioral issues.

R3-2: "I found that Theraplay is very effective to decrease both emotional and behavioral issues by using different emphases in the intervention. In order to decrease anxiety-related issues such as shyness, low self-esteem, and poor social connection, I emphasized "engagement" and "nurture" along with gradual "challenge" in the Theraplay session. By doing pure Theraplay without much cognitive in it, I saw that kids were saliently progressing in each session. For those who have behavioral issues, I had pretty big power struggles in the beginning. Many sessions, I couldn't do the activities I planned and just wrestled with the kids. My goals for those kids are usually staying and being in session without giving it up. There would be repeated set-limits for violent behavior, but I continued on without being upset and frustrated. I feel like building trust comes from being a witness to their struggles in the sessions. I often emphasized "structure" along with good attunement when I worked with kids with behavioral issues. It works eventually, but the parents need to buy my beliefs in order for lead to success."

The theme of regulation work was discussed as well. The practitioner learned that acknowledging the triggers of children's negative feelings helped children decrease their behavioral issues. Mirroring was described as another technique to decrease children's behavioral issues. To decrease emotional issues such as shyness, low self-esteem, and poor social connections, practitioners discussed that engagement and nurture activities needed to proceed before "challenge" activities. Other challenges that the practitioners experienced in sessions were medical conditions and the reluctance for parents to acknowledge their own parenting issues. Lastly, video review and consultation were suggested to help practitioners reflect on their interactions with children during sessions.

Use of the Sequence in Theraplay. Several benefits of using the sequence in Theraplay were discussed. The use of sequence in Theraplay helped the practitioner do

regulation work by having high and low arousal activities, planning sessions for creating predictability in children's behavior, and creating structure, which is important in order to create safety.

R3-1: "I use it a lot. I plan all my sessions around sequence and I plan it following the typical sequence of using special entry, special exit, and ups and downs curve in mixture in activities. I feel that's pretty important to the success of the session. It keeps children from being bored. Alternating quiet-low activities bring the child practice ups and downs arousal. I consider that important as a way of teaching regulation for kids. That's how I used it. I have no proof if that teaches regulation in the end, but that's my theory behind when I do it."

The practitioner also organized the session to be flexible around the needs of the child.

There were divergent views on following the sequence in Theraplay. Some used the flexible approach of using pure or integrative Theraplay in their work. Using the Theraplay sequence allowed the practitioners to be in the moment with the child. On the other hand, the others emphasized the importance of following the sequence in Theraplay for regulation work.

R1-2: "It depends on the family. I have had children that said, 'wait a minute. How come we don't do lotion.'" Sometime I alter the sequence to surprise the child as well. There have been a couple of times where either I've written down activities or I stop writing down the activities. Or I will change what's written down if the child happens to know them. That can be therapeutic depending on the child in terms of being helpful. It teaches more about how that child transitions and how that child adapts to the adult's control and changes like that? Yes, I think that it depends on the situation."

Also, following the sequence in Theraplay helped practitioners predict a child's impulsive or non-compliant behavior and provided them with a better repertoire in dealing with unpredictable situations. There was an opinion that the sequence was important in working with anxious and dysregulated children.

Child's regulation in Theraplay. The practitioners discussed that Theraplay activities were beneficial in increasing children's regulation. While being mindful of the children's developmental level, the practitioner selected and led the activities to increase regulation. For instance, the practitioner planned more activities on the floor for young children with small motor skills.

R9-1: "The physical component is extremely critical. Several foster care children whom I worked with were neglected, not necessarily abused. And just even being touched at all is so regulating because they haven't experience it physically. Some of the kids are bigger than me and climbed up on my lap and said, "Rock me."

Two practitioners used the words "gravity effect" to explain regulation work. Also, physical activity including touch was stressed as an important component for regulation work.

Practitioners regarded regulation work as unique in Theraplay. The importance of alternating calmer activities with boisterous activities to increase a child's regulation through Theraplay was emphasized. In addition, voice modulation, matched vitality, touch, and pacing were identified as important components of regulation work.

R9-2: "I learned greatly in Theraplay that my voice modulation is so important to increase children's regulation. Activities are important, but how we talk is more important and helps kids increase regulation through Theraplay. For instance, I love peanut butter/jelly activities to practice voice modulation. I tried to practice it with the activities and to match the vitality of the child to increase their regulation."

Theraplay's comparability to other interventions. Practitioners discussed the appropriateness of integrating Theraplay with other models. Theraplay was described as a base foundation to treat the complexity of different physiological and psychological issues.

R1-1: “I think it is the base of everything else I can do. I think of it as a solid ground work with everything all my other theories. Any other therapy and technique is based on Theraplay techniques and theory.”

The practitioners believed that Theraplay is very comparable to other therapeutic interventions such as dyadic developmental psychotherapy, trust-based relational intervention, child centered play therapy, filial therapy, and cognitive behavioral therapy. Some described Theraplay as the basis of most of the interventions.

Numeration. *Practitioners’ descriptions of Theraplay.* Regarding this topic of describing Theraplay, 89% of participants contributed to substantially in discussion to explore the crucial therapeutic factors of Theraplay. Table 23 showed the seven themes in the practitioners’ descriptions of Theraplay. “Theraplay activities” was the most frequent theme mentioned in their descriptions.

Table 23. Codes in Practitioners’ Descriptions of Theraplay

Theme	Code	<i>f</i>		
		Group 1	Group 2	Total
Attachment work	AW	10	3	13
Relationship building	RB	9	2	11
Regulation work	RW	9	7	16
Theraplay activities	TA	11	7	18
Challenges of Theraplay use	CTU	7	6	13
Compatibility to other interventions: Positive	COI-P	7	7	14

Practitioner’s evaluation of the effectiveness of Theraplay in helping foster and adopted parents. Sixteen practitioners (84%) felt that Theraplay was effective in helping foster and adoptive parents. Four themes were identified: 1) increased insight to

understand their children; 2) experiential parenting; 3) awareness of the parents' own issues in parenting; and 4) building connections with their children (Table 24). The most frequent theme that arose was the parents' increased insight to understand their children.

Table 24. Codes in Practitioners' Evaluations of Theraplay in Helping Foster and Adopted Parents

Theme	Code	<i>f</i>		
		Group 1	Group 2	Total
Increased insight to understand their children	INU	7	8	15
Learning from video review	LV	3	3	6
Experiential parenting (modeling)	EP	6	5	11
Awareness of parents' own issues in parenting	APIP	2	5	7
Building connections through activities	BCC	2	4	6

Practitioners' evaluations of the effectiveness of Theraplay in helping foster and adopted children. Lastly, all practitioners participated in a discussion on the effectiveness of Theraplay in helping foster and adoptive children. Four themes were identified: 1) connection building; 2) decreased anxiety/depression; 3) decreased temper tantrums/aggression; and 4) increased regulation (Table 25). Even though *skills gained from Theraplay* was not a formal part of focus group guide; it had the most frequency in discussion were. The sub-topics discussed were improved regulation, improved social skills, improved interpersonal plays, better coping strategies, and self-esteem building. Some of the important identifiable elements of Theraplay techniques included the use of voice modulation, noticing children's non-verbal message in words, modeling,

cognitively labeling replacement behavior, pacing, and the practice of alternating high and low arousal activities during session.

Table 25. Codes in Practitioners' Evaluations of the Effectiveness of Theraplay in Helping Foster and Adopted Children

Theme	Code	<i>f</i>		
		Group 1	Group 2	Total
Connection building	CB	3	2	5
Decreased anxiety/depression	DA/D	10	4	14
Decreased tantrums/aggression	DT/A	8	5	13
Other skills gained from Theraplay	OSGT	9	7	16
Theraplay techniques	TT	6	8	14

CHAPTER SIX

DISCUSSION

This study aimed to understand the association between the practitioners' evaluations of Theraplay, practitioners' competency, and practitioners' Theraplay practice. It examines Theraplay, an emerging intervention, for treating foster and adopted children and their families (Booth & Jernberg, 2010). As the need to identify and disseminate evidence-based interventions for the treatment of children and adolescents has been stressed across research studies (Glier & Cuella, 2003), limited and less accessible evidence-based practice for practitioners working with foster and adopted children is a concern (Dorsey, Kerns, Trupin, Conover, & Berliner, 2012).

The central purpose of this chapter is three-fold: (1) to discuss the findings from survey research regarding the association between practitioners' evaluations of Theraplay, practitioners' competency, and practitioners' Theraplay practice; (2) to discuss the findings from the case study regarding the use of Theraplay for helping adopted children and their families; and (3) to discuss the findings from the focus groups regarding practitioners' descriptions and evaluations of the use of Theraplay for helping foster and adopted children and their families.

The study employed a mixed-method research design. It drew a sample in order to best answer the five research questions using three distinct methodologies. The sampling was conducive to obtaining a higher response rate and to also gain an in-depth

understanding of the findings (Groves, Fowler, Couper, Lepkowski, Singer, & Tourangeau, 2004). The mixed-method design addresses the strengths and weaknesses of each methodological focus (Greene, 2008). It also allowed the researcher to gain a deeper understanding of this as yet under examined field of practice.

The research questions were as follows:

1. How do practitioners evaluate the use of Theraplay in treating the needs of foster and adopted children and their families?
2. How do practitioners describe that use of Theraplay in treating the needs of foster and adopted children and their families?
3. How do practitioners view the effectiveness of the use of Theraplay to help foster and adopted children and their families?
4. What is the relationship between practitioners' Theraplay practice and their evaluations of Theraplay?
5. What is the relationship between practitioners' competency and their evaluations of Theraplay?

By analyzing each of these research questions from multiple perspectives: survey research, a case study, and focus groups, this study employs triangulation to verifying the validity of these findings (Patton, 2002)

Discussion of Survey Research Findings

Discussion of the survey research findings for the research questions: “Are practitioners' Theraplay practice associated with their evaluation of Theraplay?” and “Is practitioners' competency associated with their evaluation of Theraplay?” is following:

The results of the statistical methods: descriptive statistics, correlations test, and one-way ANOVA found that there is a positive association between the level of practitioners' Theraplay training and the effectiveness of the use of Theraplay for helping foster and adopted children and their families. There is also a positive association between the level of the practitioners' competency and the effectiveness of the use of Theraplay for helping foster and adopted children and their families.

Descriptive statistics were derived from closed-ended questions related to personal characteristics and professional characteristics of the respondents. They found that the majority of participants were older, had obtained higher educational training, and had long-standing clinical experience. For instance, 49.4% were older than the age of 50, 89.7% had obtained a master's degree or higher, and 52.9 % had eight years or more of clinical experience. These results indicated that the majority of the participants had already achieved functional competency from formal training and clinical experiences with clients (De Stefano, Atkins, Noble, & Heath, 2012; Stahl, Hill, Jacobs, Kleinman, Isenberg, & Stern, 2009; Ronnestad & Skovholt, 2003).

In the professional affiliation category, the number of counselors was highest (34.5%) and the number of social workers was second highest (24.1%). According to Dafna Lender (personal communication¹), about 60% of the new trainees of Theraplay practice were social workers. "I see many social workers in Theraplay training. We usually hold up to 30 people in each Theraplay training and at least 60 % of the participants are usually social workers."

¹ Dafna Lender provides Theraplay training nationally and internationally throughout the year. She is a current training director at the Theraplay Institute (TTI)

Considering that Theraplay is such a relevant field to many social work practitioners, the number of social work practitioners (24.1%) could be increased with an emphasis on research in social work education. In exploring the various models in working with children in the foster care system, Theraplay needs to find a place for prominence. The scope of explored social work based training for clinicians and practitioners in foster care systems needs to be examined and Theraplay training made more widely accessible. The clinical knowledge and professional background of the researcher is distinctive and as found in the study less than 15% were not from USA. To make these findings applicable across foster care systems, a larger pool of sample would be helpful.

Regarding the findings from the crosstab analysis between the practitioners' level of Theraplay training and the effectiveness of Theraplay, practitioners with a higher level of training (certified Theraplay therapists and supervisors) believed that Theraplay was more effective than those with lower levels of training. For instance, 96.2 % of certified Theraplay therapists and supervisors rated an 8 or above for effectiveness (38.5% even rated the maximum score of 10), whereas practitioners with lower levels of Theraplay training rated the effectiveness from 5 to 10 (16.2% rated the maximum score of 10). Similar results were found in the crosstab analysis between the measure of competency and the effectiveness of Theraplay. Practitioners who obtained higher scores in competency reported higher scores for the effectiveness of Theraplay. For instance, 84% of respondents in group 4 (who were considered to have good competency) rated 8 or higher for the effectiveness of Theraplay. 81.4% of the respondents in group 5 (who were

considered to have excellent competency) rated 9 or higher for the effectiveness of Theraplay. Therefore, these exploratory descriptive statistics suggest that the experienced and competent practitioners might hold stronger beliefs in the effectiveness of Theraplay for helping foster and adopted children and their families.

Consistent with the findings from the descriptive statistics, the analysis obtained from the initial inferential testing using Pearson's correlations found that practitioners with more Theraplay training and more Theraplay experience achieved higher competency in Theraplay and reported more effectiveness in the use of Theraplay for helping foster and adopted children and their families. These results were consistent with the findings from the ANOVA F-tests, which found that the practitioners with higher levels of Theraplay training had reported more effectiveness in the use of Theraplay for helping foster and adopted children and their families. This analysis supports the idea that practitioners' Theraplay practice was positively associated with their evaluation of Theraplay and the practitioners' competency was positively associated with their evaluation of Theraplay.

The practitioners who have a high level of competence reported higher effectiveness of Theraplay. Furthermore, the number of years in clinical practice is accounted as an important factor to determine practitioners' competence (Ronnestand & Skovholt, 2003). For instance, Davidson et al. (2004)'s study about a correlation between competence and practice outcomes of cognitive behavioral therapy found that the practitioners who had a higher level of competence gained more successful clinical outcomes. These findings concurs that practitioners' competence can be achieved from

clinical experiences with clients (Davidson, Scott, Schmidt, Tata, Thornton, & Typer, 2004; Shaw, Elkin, Yamaguchi, Olmsted, Vallis, Dobson, Lowery, Sotsky, Watkins, & Imber, 1999; Ronnestad & Skovholt, 2003).

The findings lend themselves to further exploring the patterns of doing and evaluating practice by the levels of competency in Theraplay practitioners. For instance, the researcher wonders if there is a difference between highly competent and trained practitioners and less competent practitioners practice in other countries. Additional data informed the evaluation of practice needs to come from the client system. The client system in this case could be a family, foster care home, residential setting, and also assessment from the children. It would be changing but add to the preliminary findings.

Discussion of Case Study Findings

Discussion of the case study findings for the research questions: “How do practitioners describe the use of Theraplay in treating the needs of foster and adopted children and their families?” and “How do practitioners view the effectiveness of the use of Theraplay to help foster and adopted children and their families?” is the following:

The findings from the case study analysis added substantial details about the relationship tests about Theraplay practice. The case study illustrated Theraplay as an effective treatment in decreasing behavioral and emotional issues in one adopted child. Four subtheme areas related to decreasing behavioral and emotional issues included: (1) helping the child build a strong relationship with his caregivers, which means that Theraplay practice helps the child build intimacy and connection with his parents; (2) helping him increase self-regulation through nurture-based Theraplay activities, which

means that the child increases stability in his emotional and behavioral functioning by presenting better control in his impulsivity, temper-tantrums, and hyperactivity; (3) helping parents gain a better understanding of their child, which means that parents become able to understand the underlying needs of their child instead of focusing on the negative behavior itself; and (4) helping parents gain appropriate parenting skills, which means that parents learn to use Theraplay principles in managing their child's emotional and behavioral issues. These four factors present an overarching picture of Theraplay practice as to what factors in Theraplay lead to positive therapeutic outcomes in decreasing emotional and behavioral issues in adopted children. Interestingly, three subthemes (helping a child build a strong relationship with his caregivers, helping parents gain a better understanding of their child, and helping parents gain appropriate parenting skills) were associated with the important role of the parents in treatment. These also aligned with infant-parent research that emphasized the critical parental roles of warmth, mutuality, support, and having a healthy parent-child relationship for children (Fouts, Roopnarone, Lamb, & Evans, 2012; Haltigan, Lambert, Seifer, Ekas, Bauer, & Messinger, 2012; Bernard, Dozier, Bick, Lewis-Morrarty, Lindhiem, & Carlson, 2012).

The other two themes that emerged from the case study were: the importance of building "safety" in working with an adopted child and the consistent and long-term (one year in this case) application of attachment philosophy in building an alternative working model. These two themes are supported by the development of the field of neuroscience. According to recent neuroscience, therapeutic experience or relationship affects and alters the brain structure (Kay, 2009; Siegel & Bryson, 2011). Theoretically, a likely

explanation for the positive change in the child could be because his brain structure changed by creating new neural pathways as a result of a healthy therapeutic experience and a healthy parent-child relationship. This new relationship may have helped the child build an alternative working model, which resulted in decreased emotional and behavioral issues (Doyle-Buckwalter & Robinson, 2005).

Importantly, it should be noted that this positive change in the brain could happen with “consistent and persistent” attachment work over the course of one year, which should pose a challenge to managed care’s preferred short-term evidenced-based models in the current era. This case clearly suggested the need for long-term therapeutic intervention in order to positively alter the brain structure of a child with consistent Theraplay intervention in a persistent manner.

Discussion of Focus Group Findings

Discussion of the focus group findings for the research questions: “How do practitioners evaluate the use of Theraplay in treating the needs of foster and adopted children and their families?”, “How do practitioners describe the use of Theraplay in treating the needs of foster and adopted children and their families?”, and “How do practitioners view the effectiveness of the use of Theraplay to help foster and adopted children and their families?” is the following:

The findings of the focus groups offered more in-depth explanations of the descriptions and evaluations of the use of Theraplay for working with foster and adopted children and families. Practitioners’ discussions revealed the four main themes: (1) the meaning of Theraplay work, (2) the meaning of parenting skills in Theraplay, (3)

Theraplay factors that contribute to positive emotional and behavioral changes in children, and (4) challenges in implementing Theraplay

Theraplay work was explained to help children build a positive internal working model. Among Theraplay's seven core concepts (Booth & Jernberg, 2010, p.26), three concepts emerged as subthemes: the relationship-based model, "here and now" experience, and playfulness. Tools to utilize these concepts in Theraplay were founded in the Theraplay activities. That is, through participating in Theraplay activities, children and caregivers had the opportunity to feel a "here and now" experience, to feel fun and enjoyable moments, and to eventually build a healthy parent-child relationship (Hugh, 2004).

The meaning of "parenting skills" in Theraplay consisted of three subthemes: parents' increased understanding of the underlying meaning of their children's behavior, parents' increased sensitivity to reading signs from their child's unmet younger needs, and parents' awareness of their strengths and weaknesses in their parenting. The reviewing of videotaped sessions and direct observation/participation in Theraplay sessions were described as implementing tools. The notion of improved parenting skills could be of noteworthy importance in the attachment theory category. It might be that a parent's continuous efforts to understand the child would shift his/her views on the child. The shifted views of the parent would lead to a shift of the child's views of him/herself. Additionally, in keeping with the idea of inner working models as suggested by attachment theory, these inner models reflect the quality of early attachment experiences, and are largely unconscious and consequently do not change easily, but can be revisited

and repaired in response to experiences that do not support a current working model (Bretherton & Munholland, 1999; Hugh, 2004; Schore & Schore, 2008; Siegel, 2007).

Three of the subthemes that emerged from the Theraplay factors that contribute to positive emotional and behavioral changes in children were: 1) connection building; 2) gained regulation with the use of Theraplay activities that alternated high and low arousals and with practitioners' attuned skills such as voice modulation, matched vitality, appropriate touch, and pacing; and 3) practitioners' mirroring or modeling of positive interactions and behaviors by "cognitively labeling replacement behaviors." These taken together offer a more comprehensive list of therapeutic factors used to decrease emotional and behavioral issues in foster and adopted children. It is apparent that connection building does not solely happen in an isolated manner. It happens all together with the practitioner's consciously matched vitality, sensitive voice modulation, healthy touch, appropriate pacing while considering the child's tempo in sessions, and constant labeling of child's positive behavior. This holistic approach to client's internal system in Theraplay shows the integrity of clinical social work practice and its unique interface with creating constructed realities in the treatment of foster and adopted children and their families.

In the practitioners' discussions of challenges in implementing Theraplay for foster and adopted children, the most salient subtheme that emerged was trying to work with a "difficult parent" who "does not believe in Theraplay concepts" or "is not ready to participate in Theraplay because of their own issues." Similarly, the subtheme of the current legal system for foster care in the United States creates a space for reflection upon

children often being placed in multiple foster homes, so they did not have a primary caregiver who could participate in the Theraplay intervention. The findings from the qualitative data substantiated the claim that Theraplay could be explored further as a viable treatment for foster and adopted children.

Limitations of the Study

The researcher acknowledges several limitations inherent in the research design and scope of the current study. One of the major limitations of this study is the sample-selection approach. The sample was not randomized; rather, it was obtained from the conference site. Because respondents were Theraplay-trained professionals who received Theraplay training, self-selection bias may have played a role in the makeup of the final sample.

A second limitation of this study is that the survey relied on participant self-reports, which may not reflect their actual practices. The influence of the Theraplay spirit in the conference possibly led to having higher ratings of the effectiveness of Theraplay, either intentionally or accidentally.

Despite this researcher's significant efforts to enhance the rigor in conducting and analyzing qualitative data by reducing researcher bias and subjectivity, another drawback can be found in the focus group. Because the group makeup was not controlled, one of the focus groups was composed of Theraplay-trained practitioners who had long-term preexisting relationships. The quality of the group discussions was influenced by these relationships (somewhat desirably, but influenced nonetheless). There appeared to be

possible effects of social desirability and reactivity among respondents, which can skew the findings.

In conclusion, the findings suggest that practitioners who have more Theraplay experience and a higher level of clinical competency tend to perceive the use of Theraplay in helping foster and adopted children and their families as being more effective. Furthermore, the results derived from the study (a) fill gaps in current evidence to inform practice models, (b) particularly inform clinical work with foster and adoptive children, (c) suggest crucial components needed in skills for parenting of foster and adopted children, (d) illustrate curative factors that help foster and adopted children and their families, and (f) reveal challenges in implementing Theraplay that need to be addressed to improve its efficiency.

CHAPTER SEVEN

IMPLICATIONS AND CONCLUSION

The findings have practical, theoretical, and research implications for social work practice, education, research, and training.

1. This research uncovers therapeutic factors for adopted children and families, which can be applied across the practice of social workers. Instead of targeting the manifest behavior of the child, the findings reveal that building an alternative working model through a healthy connection with caregivers should be the foremost approach for practitioners. In order to build a connection, the clinical social worker should first consider building safety in the therapeutic environment and further support parents so they can gain skills to better understand and be sensitive to the needs of their child.
2. The participants' perspectives offered key insights to help social work practitioners consider models including parenting involvement, experiential learning, and play-based components. In addition, in order to provide consistent and persistent treatment care for this population, the integrated clinical services need to be provided in a holistic and systematic team approach. The findings reveal the factors for designing effective interventions for foster and adopted children and their families
3. These findings have implications for policy level work as they raise concerns related to the short-term intervention model that practitioners are pressured to use by managed care. It is apparent that traumatized children require long-term therapeutic

- services in order to rebuild their internal working model. Changing the brain structure in children cannot be accomplished in a short time span. The theoretical and clinical implications identified in this study stressed the “consistent and persistent” services for this population. Thus, these findings demonstrate the need for change in managed care to increase the length of mental health services for foster and adopted children.
4. This research helps to inform social work training programs and emphasizes important components for training when dealing with foster and adopted children and their families. It proves that treatment has to consider meeting the unmet younger needs of foster and adopted children who are often developmentally stuck. It is not surprising that the importance of working with the parents to increase their sensitivity and understanding of their child’s behaviors was identified as an important treatment factor. Therefore, the demand for incorporating interventions influenced by attachment theory should be foremost. The other preferred models in social work programs such as strength based perspectives, cognitive behavioral therapy, and solution focused therapy can be helpful when blended in after helping foster and adopted families build a base with attachment- based models.
 5. These findings suggest the demand for further research in Theraplay to explore the qualitative themes reported here. The next step could be to investigate actual videotaped session cases to further explore the themes emerging from the focus groups and case study. The code-book created from the current study would provide deductive themes for further research. Therefore, the future research can help predict

a number of variables that may have a positive impact on the mental health of this population.

6. These findings also suggest the importance of obtaining appropriate clinical competency assessments for practitioners in social work and in Theraplay in working with this population. The criteria for measuring clinical competency in working with children and adolescents should be revised since working with children and adolescents requires a more nuanced understanding of child development and additional technical skills when engaging and intervening with them.
7. The research suggests a model of competency measurement that is derived from the case study. The measurement needs to be refined in order to establish a comprehensive assessment of competency for this profession. Further research on the relationship between competency and positive outcomes needs to be sought.
8. Lastly, it underscores the importance of a mixed method design for exploring under examined areas. This study is able to use three different methods that offer different pieces of information in undertaking an evaluation study. Thus, it is rigorous as well as meaningful both clinically and research wide. The implications from the current investigation should aid foster and adopted children and their families, clinical social workers, foster and adoption workers, policymakers, and researchers. More importantly, these ramifications should enhance the health and well-being of foster and adopted children and their families, while providing a foundation from which to inform future research on this and related topics. This study represents the direction that social work training and practice needs to go.

In conclusion, Theraplay is an effective tool for providing services to foster and adopted children and their families. The practitioners' perspectives make a difference for both practical considerations and theoretical modifications, which are necessary in a new and under- explored field like Theraplay. The mixed-method, triangulation approach of this study is able to provide multi-dimensional meaning by supplementing the numeric survey with a case study and focus groups. Informed by the researcher's own experiences and substantive training in the field of Theraplay, this research show-cases the meeting point for clinical, theoretical, and research work in the field of social work.

APPENDIX A
SURVEY QUESTIONNAIRE

Part 1: Theraplay in Practice

The following statements are asked to explore your professional evaluation of Theraplay in your practice. Please check on the number that best corresponds to your degree of agreement about the question (10 means the most frequently used; 1 means the least frequently used). If not applicable, indicate N/A on the box.

1. **In my practice**, Theraplay contributes to caregiver's increased understanding of their children's needs.

1 2 3 4 5 6 7 8 9 10 N/A

2. **In my practice**, Theraplay contributes to caregiver's increased appropriate parenting skills in dealing with their children's issues

1 2 3 4 5 6 7 8 9 10 N/A

3. **In my practice**, Theraplay contributes to a healthy relationship between parent – child.

1 2 3 4 5 6 7 8 9 10 N/A

4. **In my practice**, Theraplay contributes to decrease child's behavioral (or emotional) symptom.

1 2 3 4 5 6 7 8 9 10 N/A

5. **In my practice**, I include the elements of the sequence in Theraplay sessions (The Opening, The Session proper, and the Closing)

1 2 3 4 5 6 7 8 9 10 N/A

6. **In my practice**, I use Theraplay principles (4 dimensions and 7 core concepts) to plan Theraplay sessions.

1 2 3 4 5 6 7 8 9 10 N/A

7. **In my practice**, I use “noticing” for children's non-verbal and verbal message.

1 2 3 4 5 6 7 8 9 10 N/A

8. **In my practice**, I consider children's optimal arousal in Theraplay sessions.

1 2 3 4 5 6 7 8 9 10 N/A

9. **In my practice**, I regularly schedule sessions without the child for parents to view and discuss Theraplay sessions.

1 2 3 4 5 6 7 8 9 10 N/A

10. Children treated in Theraplay practice are more likely to have a good therapeutic outcome.

1 2 3 4 5 6 7 8 9 10 N/A

11. How effective is Theraplay compared to other therapeutic interventions in your practice?

1 2 3 4 5 6 7 8 9 10 N/A

List other effective interventions used:

Part 2: Theraplay Competency

Please read a sample vignette below and answer the following questions:

Bill is a four year and three month year old Caucasian boy who resides with his aunt's family. Bill was removed from his biological mother when he was six months old due to his mother's instability in care giving. His mother was a drug addict and diagnosed with bipolar disorder. Bill had been raised in two different foster homes before he began to live with his aunt (Jan) about a year ago. Jan is married, and has a one and a half year old son.

Bill has received Physical Therapy, Speech Therapy, and Occupational Therapy since he was six months old. He is developmentally far below compared to his age group. According to Jan, Bill is "immature and babyish" and fails to follow any direction given at home. Jan was concerned about Bill's low level of social functioning. Jan stated that Bill was spoiled by the previous foster parents who failed to give him the proper discipline. Therefore, Jan and her husband Scott have worked hard to teach Bill about good behaviors and family rules. However, they recently noticed that Bill becomes more defiant, oppositional and somewhat manipulative in the interactions with them.

1. What are your goals for Bill in Theraplay?
2. What are your goals for parents in Theraplay?
3. Which two dimensions does Bill need the most in Theraplay?
4. Plan your first Theraplay session for Bill.
5. What other intervention(s) do you consider either in place of Theraplay or additional to Theraplay?

Part 3: Professional Characteristics

1. Professional Affiliation
 - ☐ Social Work ☐ Counseling ☐ Psychology ☐ Family and Marital Therapy
 - ☐ Child Development ☐ Others _____
2. Highest Degree Completed:
 - ☐ Bachelor Degree ☐ Master Degree ☐ Ph.D/ or Doctoral Degree
3. Level of Theraplay Training
 - ☐ Completed Introductory Training
 - ☐ Completed Intermediate Training
 - ☐ Level 1 Practitioner (Introductory training + 8 supervision)
 - ☐ Level 2 Practitioner (Introductory and Intermediate training + 20 Supervision + Pass Mid-Term)
 - ☐ Certified Theraplay Therapist
 - ☐ Certified Theraplay Supervisor
4. Number of Years in Clinical Practice:

5. Number of Years in Theraplay Practice
 6. Population Served (check all that apply)
 - ☐ Adopted Children/ Families
 - ☐ Foster Children/ Families
 - ☐ Reunification Cases
 - ☐ Domestic Violence Cases
 - ☐ Relational Problem with biological children
 - ☐ Others (please list below)
-

Part 4: Personal Characteristics

1. Age:
 - ☐ 20-29
 - ☐ 30-39
 - ☐ 40-49
 - ☐ 50-59
 - ☐ 60-69
 - ☐ 70 over
2. Gender:
 - ☐ Male
 - ☐ Female
 - ☐ Other ()
3. Country to Practice:
4. Ethnicity:
5. Marital Status:
 - ☐ Single
 - ☐ Married
 - ☐ Divorced
 - ☐ Other()

(Optional) Are you willing to provide descriptions of case using Theraplay?

- ☐ Yes (Please write your email:)
- ☐ No

APPENDIX B
RESEARCH DOCUMENT

RECRUITMENT LETTER

Dear Christen,

As we have discussed about my research project, I am conducting a study examining practitioners' evaluations of the use of Theraplay as an effective tool in serving foster and adoptive children and their families. Respondents will be asked to complete a questionnaire related to how they would practice Theraplay and how they evaluate their practice. This will be followed by a short case study designed to measure their Theraplay competency. For certified Theraplay therapist, they will be asked to describe a case using Theraplay (optional). The study will last approximately 15-20 minutes. The respondents will be informed that their participation is entirely voluntary and that they may withdraw without penalty at any time. There is no monetary reward for this study.

I appreciate your help to provide a booth for this research recruitment purpose during the 6th International Theraplay Conference in July 12-13, 2013. For further questions related to the study, please contact me at 224-715-7755 or rhong1@luc.edu

Sincerely Yours,

Rana Hong

Ph.D candidate at Loyola University Chicago

INFORMED CONSENT ATTACHED IN SURVEY QUESTIONNAIRE

You are asked to participate in a research study on your evaluation on the use of Theraplay as an effective tool in working with foster and adoptive children and their families. This study is conducted by Rana Hong, LCSW, a PH.D candidate at the school of social work in Loyola University Chicago.

This study will take approximately 15- 20 minutes of your time. You will be asked to complete a short questionnaire related to how you practice Theraplay and how you evaluate your Theraplay practice. This will be followed by competency measure. For certified Theraplay therapists, you will be asked to provide your email address if you desire to provide cases using Theraplay (optional).

Your decision to participate or decline participation in this study is entirely voluntary and you have the right to terminate your participation at any time without penalty. You may skip any questions you do not wish to answer. If you want do not wish to complete this survey just stop the survey.

Your participation in this research will be completely confidential and data will be averaged and reported in aggregate. Although your participation in this research may not benefit you personally, it will help us abridge the gaps between Theraplay practice and research and increase the understanding of Theraplay in working with foster and adoptive children and families.

There are no risks to individuals participating in this survey beyond those that exist in daily life. Information from this research will be used solely for the purpose of this study and any publications that may result from this study.

If you have questions about this research, you may contact Rana Hong at 224-715-7755 or rhong1@luc.edu. If you have any questions about your rights as a participant in this study or any concerns or complaints, please contact Loyola Institutional Review Board at 773-508-2471 or ors@luc.edu.

Please keep this consent form for your records, if you so desire.

INFORMED CONSENT FOR FOCUS GROUP PARTICIPANTS

I am Rana Hong, a Ph.D candidate at the school of social work in Loyola University Chicago(LUC). I am inviting you to participate in the focus group to discuss your evaluations of the use of Theraplay as an effective tool in working with foster and adoptive children and their families. The focus group is part of my research conducted under Dr. Shweta Singh at LUC.

The focus group will take approximately 60 minutes of your time. There will be eight questions to discuss in the focus group. Your decision to participate or decline discussion is entirely voluntary and you have the right to terminate your participation at any time without penalty. You may refuse any question you do not wish to discuss. If you do wish to withdraw during the focus group just leave the room any time in your convenience.

Your participation in this research will be completely confidential. All information obtained in the focus group will be kept strictly confidential. All participants will be asked not to disclose anything said within the context of the discussion. All identifying information will be removed from the collected materials, and all materials will be kept in the researcher's computer.

Although your participation in this research may not benefit you personally, it will help us abridge the gaps between Theraplay practice and research and increase the understanding of Theraplay in working with foster and adoptive children and families.

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this study.

Participant's Signature _____

APPENDIX C
CODE BOOKS

Table C1. Initial (Closed) Code-Book for Practitioners' Evaluation of Theraplay

Main categories	Subcategories	Codes	Operational definitions
Practitioner's description of Theraplay	Internal Working model	IWM	Account of how a person perceives him/herself, others, and the world base on his/her early parent-child relationship experience
	Use of Theraplay Dimensions	UTD	Account using four dimensions such as structure (safety), challenge(competence), nurtre (care), and engagement (shared joy)
	Use of Theraplay Core Concept: relationship based	UTC-RB	Mentions of relationship based work, attachment work, reunion/repair work.
	Use of Theraplay Core Concept- hear and now	UTC-HN	Mentions of direct here and now experience, experiential
	Use of Theraplay Core Concept: adult guide	UTC-AG	Mentions of adult guidance, adults in charge, adult lead
	Use of Theraplay Core Concept:attunement	UTC-A	Mentions of use of responsiveness, attunement, empathy, and reflectiveness.
	Use of Theraplay Core Concept: Right brain work	UTC-RBW	Mentions of preverbal, social brain, emotional brain, right brain work.
	Use of Theraplay Core Concept: Multi-sensory	UTC-MS	Mentions of touch, sensory work.
	Use of "noticing"	UN	Practitioners' verbalization of the child's inner needs in words.
	Use of Theraplay sequence	UA	Mentions of the session's structure. For instance, entrance, checking, greeting, mixture of activities, feeding, and exit
	Meeting younger needs	MYN	mentions of providing young play, activities
	Consideration of optimal arousal	OA	Mentions of considering children's level of arousal in session

Main categories	Subcategories	Codes	Operational definitions
Practitioner's evaluation on Theraplay	Parent's participation	PP	Mentions of parents' involvement or roles in treatment
	Compatitbility with other interventions: positive	COI-P	Favorable mentions of Theraplay's comparability with other intervention
	Compatitbility with other interventions: negative	COI-N	Negative mentions of Theraplay's comparability with other intervention
	Use of MIM	MIM	Mentions of the use of MIM in Theraplay
	Caregivers' understanding of children's needs	CUN	Favorable mentions of caregiver's increased understanding of children's needs
	Caregiver's parenting skills	CPS	Favorable mentions of caregiver's increased parenting skills
	Healthy parent-child relationship	HR	Favorable mentions of relationships building with parents and others
	Decrease children's behavioral symptoms	DCB	Favorable mentions of behavioral symptotms change in children
	Decrease children's emotional symptoms	DCE	Favorable mentions of emotional symptoms change in children
	Age of use : Young	AU-Y	Favorable mentions of Theraplay for young children
	Age of use: all	AY-A	Favorable mentions of Theraplay for all age
	Challenge of Theraplay use	CTU	Mentions of any challenges, obstacles in the use of Theraplay . For instance, resistance of parents or difficult situation.
	Therapeutic outcome: positive	TO-P	Favorable evaluation of Theraplay. For instance, words of 'effectiveness' or 'working' in treatment
	Therapeutic outcome: negative	TO-N	Negative evaluation of Theraplay
Practitioner's Competency	Competency	C	Mentions of years of practice, training, self-evaluation of clinical work

Table C2. Revised (Inductively Created) Code-Book for Practitioners' Evaluation of Theraplay

Themes	Subthemes	Codes	Operational definitions
Practitioner's description of Theraplay	Attachment Work	WK	Accounts of building internal working model: how a person perceives himself, others, and the world based on parent-child relationship.
	Relationship Building	RB	Accounts of building closeness and connection with others
	Regulation Work	RW	Accounts of alternating high and low arousal activities.
	Theraplay Activities	TA	Accounts of interactive activities listed in Theraplay book.
	Challenges of Theraplay Use	CTU	Accounts of obstacles in the use of Theraplay
Practitioners' evaluations of the use of Theraplay with parents	Compatibility to other intervention: Positive	COI-P	Favorable mentions of Theraplay's compatibility to other interventions.
	Increased insight to understand their children	INU	Accounts of caregiver's increased understanding of children's needs
	Learning from video review	LV	Accounts of benefits from using video-taped session review with parents
	Experiential parenting	EP	Accounts for parents' direct involvement in the sessions.
	Awarenes of parents' own issues in parenting	APIP	Accounts for parents' problems or difficulty that interfere with parenting
Practitioners' evaluations of the use of Theraplay with children	Building connections through activities	BCC	Accounts for positive relationship building experience between parent and child
	Connection Building	CB	Accounts for positive relationship building between practitioner and the child

Themes	Subthemes	Codes	Operational definitions
	Decreased Anxiety/Depression	DA/D	Favorable mentions of emotional symptoms change in child
	Decreased Tantrums/Aggression	DT/A	Favorable mentions of behavioral symptoms change in child
	Other skills Gained from Theraplay	OSGT	Accounts of social skills, coping skills, interplay skills, and positive self-esteem
	Theraplay Techniques	TT	Accounts for voice modulation, attunement, matched vitality, noticing, appropriate pacing in sessions

APPENDIX D

FOCUS GROUP INTER-RATERS RELIABILITY CHECK

Table D1. Sample Focus Group Inter-Rater Reliability Check

	Coder 1 (Researcher)	Coder 2 (Peer- researcher)	% agreement
1. How do you feel about Theraplay work for foster and adopted children and their families?			
R1. I think it is the treatment choice of children aged 6 and under.	MYN	MYN	100
R2: I've used it with older children but cautioned if I used it with children in foster care because it is unknown if children will return to family. I don't want to start attachment work and have it disrupted.	UTC-RB, CTU	UTC-RB	75
R3: I use it virtually with anybody because I don't see it as causing in attachment that necessarily broken. I see it as producing good relationship skills which kids in foster care wherever they go need to develop with somebody. Kids need to experience good parenting so I go ahead of using with anybody as long as they are going to be in that placement for three months and more. I say "bring him in let's do some relationship building activities."	UTC-RB, CTU	UTC-RB	75
R4: I think that is the hardest part with foster families and adopted families. You got a wait for the window time to allow them to have relationships in the home. Instead, the family is sometimes very desperate for assistance. To have that delayed of doing intake, doing the MIM, doing feedback and then doing parent sessions make their feelings are distanced and delayed. I know you can fast track that but waiting that window three months before you start sometimes very difficult for them or difficult for their case managers who want to have interventions now and help the child placement agency understand the relationship piece you got to establish.	UTC-RB, CTU	UTC-RB	75
R5: Theoretically speaking, we know that children who have secure base separate more easily. So, you can argue that even in the relationship experience, child needs to take what he can take. Has some good take home. Also, more he can have capacity to start the secure base, the easier will be for him to move on. To take and more on. And reestablish again. And station.	IWM	IWM, UTC-RB	75
R6 : This is based on my experience. What I've been doing so often, especially the children that have had multiple, multiple, multiple placements, their ability to form attachment and then destruct it again and cope with that is not real strong. This is probably just the system is in Texas. Cases can be prolonged, prolonged, prolonged. With that, multiple placements, placements, placements, and my experience has been if I have him form the attachment with one particular caregiver and that's broken, there are repercussions for next caregiver, lack of trust. This is going to last? So they are really reluctant to attach. I feel like I	UTC-RB, CTU	UTC-RB	75

	Coder 1 (Researcher)	Coder 2 (Peer- researcher)	% agreement
start all over every time.			
R7 : There is also an option of using Theraplay techniques not being stuck with exactly like the model says. Do it this way or that way. There is a piece having co-regulating, positive attachment experiences with therapist, caregivers, foster parents where you don't have to decide that your goal for therapy is that they are going to form an attachment with this caregiver and then...I don't think it is Texas thing I think it is entire system.	UTC-RB	UTC-RB, UTC-MS	75
Other Respondents. (Sounds of agreements)			
R7 : I don't know for me when you ask what do I think of Theraplay, I obviously like it and use it a lot but I don't use in any sort of strict manner where this is how I have to do MIM and wait this amount of time. I can throw Theraplay activities at the first time I meet someone if it is clinically appropriate to do so.	N/A (Flexible use of Theraplay)	n/a (effective regardless of timeline)	100
R8 : In terms of your question about foster and adopted children, I agree with you I think it is the treatment of choice for younger children.	MYN, AU-Y	MYN	75
Facilitator: Because?			
R8: Because I think that it is unique Therapy that gets at the very early preverbal issues of trust and attachment building that children so desperately need and that other things can help but I think you always still have underlying mistrust underlying sense of self that is damaged.	IWM, UTC-RB	IWM, UTC-RB	100
R7: Why it's 6 and under? I am just curious. Because I use so much so many older clients so wondering why specifically six and under.	AU-A	n/a (effective regardless of child's age)	100
R8: I think for me Theraplay modifications where you at cognitive pieces to it and verbal pieces for children who are older they need that. But I think that isn't pure Theraplay. I think it is for really younger children.	MYN	MYN	100

	Coder 1 (Researcher)	Coder 2 (Peer- researcher)	% agreement
Facilitator: Ok. Pure Theraplay is for younger children.			
R9: Creating an alternative working model is often done with goals and actions for children. There caregivers were not there when the children first developed their internal working model. I work with birth parents that blocked some f their parenting aspects. I am helping children make an alternative working model with their parents, even though they end up being placed at foster care. When they have a chance to build an alternative working model, their transition to a new place (foster care) is much easier and smoother. Although they experience the loss of their parents, they are reacting like “Ok, I won’t be with my parents, but I have a great connect with my parents and they will always love me.” The shift in their views (from alternative working model) help them reduce their behavioral problems and make them do better in a new foster home. These children always remember their Theraplay experience and I think I was the attachment figure in their alternative model.”	IWN, UTC-RB	IWM(1), UTC-RB(2)	100
R2: The new relationship created from Theraplay protects children when they are placed in foster care homes. I know some of you use Theraplay for young children but I often use it with adolescents that are frozen in their younger emotional stage. The kids need to be seen and felt and heard.”	UTC-RB, IWM	IWM(1), UTC-A(2)	50

APPENDIX E

COMPETENCY MEASURE THEME CHART

COMPETENCY MEASURE THEME CHART

Questions	Component 1	Component 2	Component 3
Goals for child (3, 2, 1)	Experience adult's understanding of his ability and needs	Experience affective connection	Experience himself as lovable, special & worthy
		(Available/sensitive/responsive adult)	
Goals for parents (3, 2, 1)	Provide developmentally appropriate S/C	Attune to child's emotional/cognitive state	Help child feel safe, accepted, good and special
	(Understand developmental level, capability, impact of attachment)	(child's signals, reasons for behavior)	
Two dimensions (2, 1)	Nurture	Engagement	(Structure)
Session Plans (3, 2,1)	Selected activities correspond to two dimensions chosen as "needed most"	Selected activities are appropriate for younger developmental age and needs	Selected activities follow typical sequence of session
Other interventions	Play Therapy	Some type of trauma-history processing like DDP, EMDR	Parent's own therapy
Each component will be 1 point.			
The sum of total will be another variable called as Sum of Competency rating:			
	11 points = rated 5		
	8 -10 points = rated 4		
	5- 7 points above = rated 3		
	2 -4 points above = rated 2		
	0-1 points above = rated 1		

First Coder: Rana Hong

Date: 9/8/2013

Score: 0,1, 2,3 (3 is highest)

Randomly Selected Number	Goals for Child	Goals for Parents	Two Dimensions	Session Plans
74	1	2	0	1
21	2	2	2	3
20	3	2	2	3
72	1	2	2	0
39	1	1	2	0
81	2	2	2	2
73	1	1	2	1
69	1	3	2	3
55	1	2	2	3
56	1	2	2	3

Second Coder: Sandra Lindaman

Date: 9/8/2013

Randomly Selected Number	Goals for Child	Goals for Parents	Two Dimensions	Session Plans
74	1	1	0	1
21	2	2	2	2
20	2	3	2	3
72	2	2	2	0
39	1	1	2	0
81	1	3	2	2
73	2	1	2	1
69	1	3	2	2
55	1	2	2	3
56	1	2	2	3

Percentage Agreement: 87.5 %

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VITA

Dr. Hong attained her Bachelor of Arts degree from Sookmyung Women's University in Korean in 1996. Upon graduation, Dr. Hong came to the U.S. to pursue her graduate studies at Jane Addams College of Social Work in University of Illinois at Chicago. After obtaining a Master of Social Work degree in 2000, Dr. Hong devoted her full energy to advancing her clinical and managerial experiences. Dr. Hong worked as children's social worker, parent educator, supervisor, director, trainer, and advocate for the well beings of children and their families. For instance, Dr. Hong was a core member who set up the infrastructures in the children's program at World Relief-Chicago and run the mental health department at Korean American Community Services. In addition, Dr. Hong is uniquely specialized in play therapy, Theraplay and Parent-Child Interaction Therapy. As a registered play therapy and Theraplay supervisor, Dr. Hong is regularly invited to offer play therapy training in Korea.

With her commitment of abridging the gap between practice and research, Dr. Hong entered the doctoral program in the School of Social Work at Loyola University Chicago in 2008. While completing her doctoral degree at Loyola University Chicago, Dr. Hong has continued her clinical practice by running a group practice named Playful Healing Center with a mission of healing and strengthening children, adolescents, and their families. She is currently an adjunct professor at Loyola, teaching a range of clinical

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